COMMITMENT
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July 17, 2025
Report 2024-115
FACT SHEET

Grant Parks *California State Auditor*

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The Division of Occupational Safety and Health

Process Deficiencies and Staffing Shortages Limit Its Ability to Protect Workers

Background

As part of the Department of Industrial Relations (DIR), the Division of Occupational Safety and Health (Cal/OSHA) enforces workplace standards to protect and improve the health and safety of California's 20 million workers. This process generally involves Cal/OSHA personnel deciding whether to conduct an on-site inspection of a workplace—typically after receiving a health or safety complaint or learning of a worker fatality, injury, or illness (accident)—and issuing citations and fines according to the results of the inspection. Our audit included a review of 60 complaint and accident case files that Cal/OSHA handled from fiscal years 2019–20 through 2023–24.

Our Key Recommendations

- Cal/OSHA should revise its policies and procedures to ensure that personnel do the following:
  - » Provide thorough rationales that explain how their decisions not to conduct on-site inspections of complaints or accidents align with specific policy requirements.
  - » Document detailed IIPP evaluations in each inspection case file, including an assessment of how well the employer has implemented the IIPP in practice.
  - » Obtain supporting evidence proving that employers have abated violations that Cal/OSHA has identified.
  - » Include rationales and evidence in the case file for each component of their fine calculations and for any subsequent fine reductions they negotiate with employers.
- DIR should document and implement a plan for reducing the vacancy rate in Cal/OSHA's enforcement branch to 20 percent or less.

Key Findings

- Cal/OSHA did not document sufficient reasons for closing some workplace complaints and accidents without conducting an on-site inspection.
  - » We questioned Cal/OSHA's rationale for deciding not to inspect nine of 30 uninspected complaints we reviewed. The case files lacked evidence to support that Cal/OSHA had complied with its own policies. In one case, for example, Cal/OSHA did not inspect a complaint alleging that high kitchen temperatures resulted in a worker receiving emergency medical treatment.
  - » Some accident cases lacked documentation to support Cal/OSHA's decision not to inspect. In one case, a worker suffered a laceration, requiring surgery and an overnight hospital stay, yet Cal/OSHA did not explain in the case file why the injury did not warrant an inspection.
- When it does conduct on-site inspections, Cal/OSHA's process has critical weaknesses.
  - » Cal/OSHA did not consistently document effective reviews of employers' injury and illness prevention programs (IIPP), which provide safeguards against hazards. One fatal accident case file we reviewed contained no evidence that the inspector evaluated the employer's IIPP, even though there were indications that an IIPP violation may have occurred.
  - » Cal/OSHA took weeks or even months to initiate some complaint and accident inspections. In two cases, it took over a month to initiate inspections of complaints when state law required inspections to begin within three working days.
- Cal/OSHA could better ensure that employers maintain safe workplaces.
  - » When Cal/OSHA identified hazards and cited employers for violations, it did not always document evidence that employers had abated those hazards.
  - » The fines that Cal/OSHA assessed employers were sometimes less than may have been warranted. In one worker fatality, Cal/OSHA assessed a $21,000 fine but may have been able to fine the employer nearly twice as much.
- Staffing shortages and process deficiencies—such as out-of-date policies—are root causes for many of the concerns we identified. Cal/OSHA had a 32 percent vacancy rate in fiscal year 2023–24, and its vacancy rate was higher for certain district offices and inspector positions.

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July 2025

REPORT 2024-115

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Grant Parks *State Auditor*

Mike Tilden *Chief Deputy*

July 17, 2025
2024-115

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, my office conducted an audit of the Division of Occupational Safety and Health (Cal/OSHA) and its efforts to enforce health and safety standards that protect California's nearly 20 million workers. We reviewed 60 case files that Cal/OSHA handled from fiscal years 2019–20 through 2023–24 and found deficiencies in Cal/OSHA's enforcement processes and staffing levels that may undermine some of California's workplace protections.

In general, we determined that Cal/OSHA did not demonstrate that it had sufficient reasons for closing some workplace complaints and accidents without conducting an on-site inspection. In nine of the 30 uninspected complaints we reviewed, we questioned Cal/OSHA's rationale for deciding not to inspect because the case files lacked evidence to support that Cal/OSHA had complied with its own policies. Some accident cases also lacked support for Cal/OSHA's decision not to inspect.

We also observed some critical weaknesses among the on-site inspections that Cal/OSHA did conduct. Cal/OSHA did not consistently document effective reviews of employers' injury and illness prevention programs, causing us to question whether it may have overlooked potential violations in some instances. When Cal/OSHA identified hazards and cited employers for violations, it did not always document that those employers had abated the hazards. Furthermore, the fines that Cal/OSHA assessed employers were sometimes less than the violations may have warranted, and Cal/OSHA often did not document a clear rationale for further reducing fines in post-citation negotiations with employers.

Cal/OSHA's process deficiencies and staffing shortages are root causes for many of the concerns we identified. Cal/OSHA has left key policy documents unrevised for years, conducted internal audits inconsistently, and relied on paper-based case files. Cal/OSHA had a 32 percent vacancy rate in fiscal year 2023–24 and even higher vacancy rates in many of its district offices, significantly limiting its ability to protect workers.

Respectfully submitted,

GRANT PARKS
California State Auditor

Selected Abbreviations Used in This Report

Cal/OSHA	Division of Occupational Safety and Health
DIR	Department of Industrial Relations
Federal OSHA	Occupational Safety and Health Administration
IIPP	Injury and illness prevention program

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Summary

Key Findings and Recommendations

The Division of Occupational Safety and Health—better known as Cal/OSHA—is the division of the Department of Industrial Relations (DIR) tasked with protecting and improving the health and safety of California's nearly 20 million workers by enforcing the workplace protections state law requires employers to provide. This enforcement process, which was the focus of our audit, generally involves Cal/OSHA personnel deciding whether to conduct an on-site inspection of a workplace—typically after receiving a health or safety complaint or learning of a worker fatality, injury, or illness (accident)—and issuing citations and fines according to the results of the inspection. Our audit included a review of 60 case files that Cal/OSHA handled between fiscal years 2019–20 and 2023–24, and we found deficiencies in Cal/OSHA's processes and staffing levels that may undermine some of California's workplace protections.

Cal/OSHA Did Not Inspect Some Complaints and Accidents, Despite Evidence That an Inspection May Have Better Protected Workers

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Of the 60 case files we reviewed, 30 related specifically to Cal/OSHA's decision-making about whether an on-site inspection was necessary for a complaint. In nine of those 30 cases, we question Cal/OSHA's rationale for deciding not to conduct on-site inspections. In at least five additional cases, Cal/OSHA followed its policies in deciding not to inspect on-site, but we found factors indicating that inspections may have helped better protect workers. Further, when Cal/OSHA investigated complaints by letter—essentially, by sending the employer a letter requesting that it address alleged hazards—Cal/OSHA often closed cases even when it lacked sufficient supporting evidence that the employer had addressed all the alleged hazards.

We also reviewed case files for seven accidents that Cal/OSHA decided not to inspect and had concerns about Cal/OSHA's decision in six of them, mainly because the case files lacked a clear rationale for why inspections were unnecessary. Cal/OSHA has broad statutory authority to inspect accidents, but state law and Cal/OSHA's policies require inspections only of fatalities or of cases with the most severe injuries. In the cases we reviewed, workers sometimes sustained injuries that required emergency medical treatment, yet Cal/OSHA did not investigate the causes of those accidents.

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When It Does Perform Inspections, Cal/OSHA's Process Has Critical Weaknesses

Among the on-site inspections Cal/OSHA did perform, we observed some common weaknesses. For example, the case files we reviewed were not always thorough enough to support Cal/OSHA's decision-making. Notably, Cal/OSHA enforcement personnel did not consistently document effective reviews of employers' injury and illness prevention programs—which are key safeguards against dangerous hazards—nor did they include in the case files detailed notes from interviews they conducted with workers. Further, Cal/OSHA took weeks or even months to initiate some inspections of complaints and accidents: in two cases, it took over a month to initiate inspections of complaints when state law required inspections to begin within three working days.

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Cal/OSHA Could Better Ensure That Employers Maintain Safe Workplaces

By conducting on-site inspections, Cal/OSHA can require abatement of violations it identifies, issue citations and fines to employers, and sometimes refer cases to prosecutors if employers' violations may have been criminal in nature. However, we identified shortcomings in each of these areas. The complaint and accident inspections we reviewed often lacked supporting evidence that employers had abated violations, reducing assurances that workers were safer as a result of those inspections. In addition, Cal/OSHA's initial fine determinations for some complaint and accident inspections were less severe than regulations and policy may have warranted, such as one worker fatality for which Cal/OSHA assessed a $21,000 fine but may have been able to fine the employer nearly twice as much. Cal/OSHA often did not document a clear rationale for its decisions to reduce fines in post-citation negotiations with employers, such as by explaining why reductions were reasonable given the employer's assertions. Further, Cal/OSHA's bureau of investigations did not document that it performed its own reviews of some accidents and, for others that it did review, it did not clearly explain why it chose not to refer them for potential criminal prosecution.

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Cal/OSHA Must Address Shortcomings in Its Staffing Levels and Oversight

Understaffing and process deficiencies are root causes for many of the concerns we identified. Cal/OSHA had a 32 percent vacancy rate in fiscal year 2023–24, and its vacancy rate was even higher in its enforcement branch. Nearly all 24 regional and district managers we interviewed

told us that their offices would have conducted more on-site inspections and inspected more thoroughly if their offices had been adequately staffed. Compounding the effects of understaffing, many of Cal/OSHA's policies and procedures have been out-of-date for years. In addition, Cal/OSHA did not consistently conduct ongoing audits of its case files to ensure that staff were implementing its policies and procedures correctly. Cal/OSHA's processes have been largely paper-based, which is inefficient and increases its risk of having poor case file documentation.

To address these findings, we have made recommendations to Cal/OSHA to update its policies, modernize and document its procedures, and increase its staffing levels so that it can conduct more on-site inspections of workplaces and better protect workers.

Agency Comments

DIR indicated it would implement our recommendations and provided additional context about the efforts it has been making to address the concerns we identified.

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Introduction

Background

Both federal and state law require employers to provide safe and healthy workplaces and to do anything reasonably necessary to protect the life, safety, and health of workers. The federal Occupational Safety and Health Administration (federal OSHA) oversees Cal/OSHA in its efforts to ensure that employers provide such workplace protections for workers in California. Cal/OSHA is tasked with protecting and improving the health and safety of California's nearly 20 million workers and, with limited exceptions, has broad jurisdiction over nearly every workplace in the State. Employers in California must abide by workplace regulations that the Occupational Safety and Health Standards Board sets and that Cal/OSHA enforces. In addition to its enforcement efforts, which were the subject of this audit, Cal/OSHA also performs functions such as providing education and outreach to employers and workers and issuing permits for elevators and amusement rides.

Cal/OSHA's Enforcement of Workplace Health and Safety

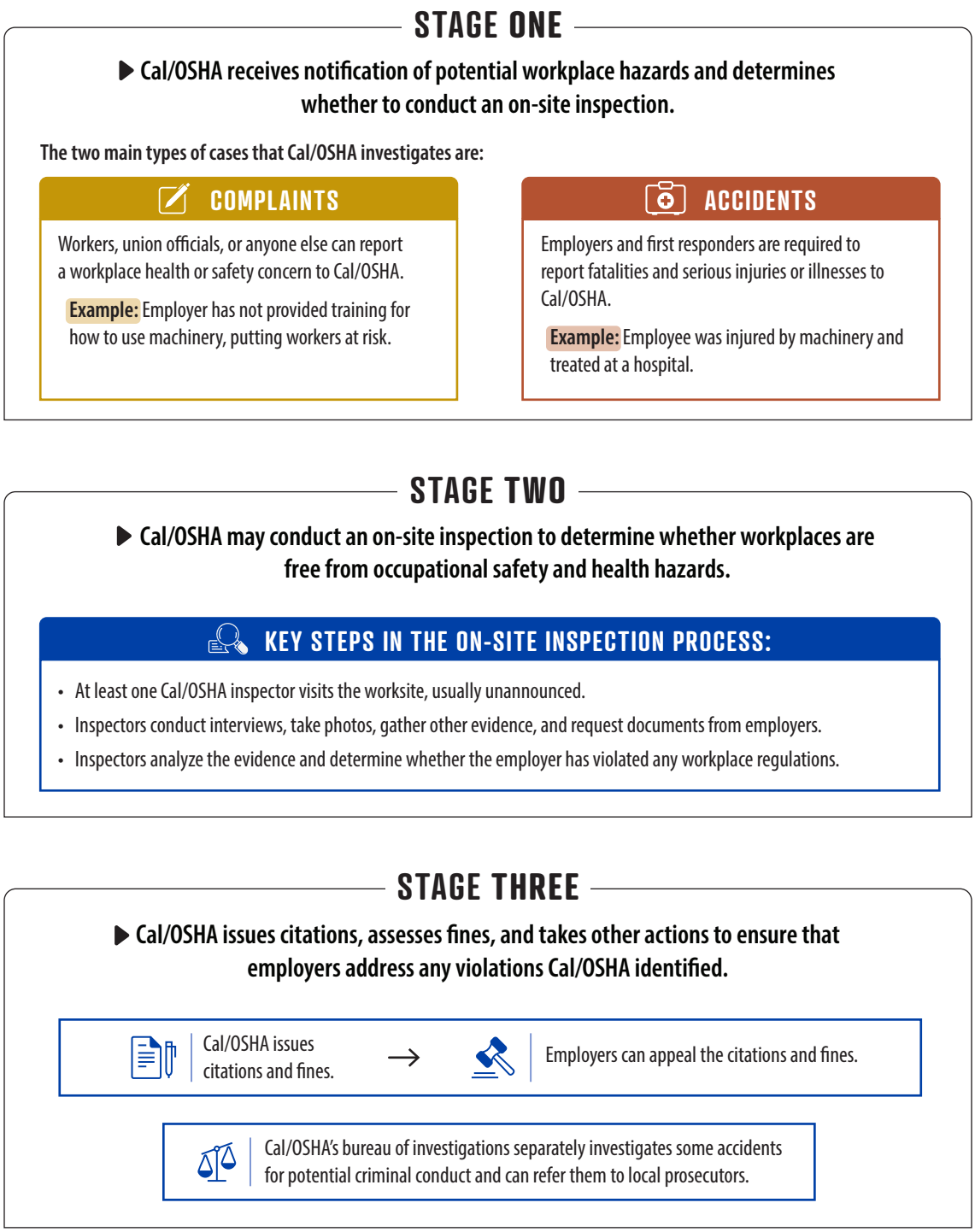
Cal/OSHA's enforcement of workplace health and safety standards involves a process consisting of three key stages, as Figure 1 shows. The process generally involves deciding whether to conduct an on-site inspection of a workplace—typically after receiving a workplace health or safety complaint or learning of an accident—and issuing citations and fines according to the results of the on-site inspection.

Cal/OSHA has an enforcement branch that carries out this process. As of 2024, the enforcement branch consisted of 17 district offices across the State that handled most inspections.[1] Four regional offices, each with a regional manager, oversaw these 17 district offices. The enforcement branch also has other specialized offices and units that usually focus on particular types of workplaces or inspections, such as offices focused on employers that conduct mining and tunneling. A district office or specialized unit typically has a district manager who oversees the office or unit, certified safety and health officials (inspectors) who conduct inspections, and support staff.

Cal/OSHA's legal unit also plays an important role in the enforcement process, including by advising and assisting enforcement personnel. Within the legal unit is the bureau of investigations, which coordinates with enforcement personnel and prepares certain accident cases for referral for potential criminal prosecution to the appropriate prosecutorial authority, such as a local district attorney. Such authorities can then prosecute employers for negligently or willfully violating workplace safety or health standards, which can result in criminal sanctions, such as imprisonment or additional fines. The bureau of investigations may work on a case concurrently with the enforcement branch or after the enforcement branch has completed its on-site inspection. The bureau's work is separate from the enforcement branch's inspections and citations.

[1] During 2024 and 2025, Cal/OSHA has been in the process of opening additional district offices in Riverside and Santa Barbara and opening new offices focused specifically on enforcement in the agriculture industry.

Figure 1
Cal/OSHA's Enforcement Process Includes Three Key Stages


STAGE ONE
Cal/OSHA receives notification of potential workplace hazards and determines whether to conduct an on-site inspection.
The two main types of cases that Cal/OSHA investigates are:
COMPLAINTS
Workers, union officials, or anyone else can report a workplace health or safety concern to Cal/OSHA.
Example: Employer has not provided training for how to use machinery, putting workers at risk.
ACCIDENTS
Employers and first responders are required to report fatalities and serious injuries or illnesses to Cal/OSHA.
Example: Employee was injured by machinery and treated at a hospital.
STAGE TWO
Cal/OSHA may conduct an on-site inspection to determine whether workplaces are free from occupational safety and health hazards.
KEY STEPS IN THE ON-SITE INSPECTION PROCESS:
At least one Cal/OSHA inspector visits the worksite, usually unannounced.
Inspectors conduct interviews, take photos, gather other evidence, and request documents from employers.
Inspectors analyze the evidence and determine whether the employer has violated any workplace regulations.
STAGE THREE
Cal/OSHA issues citations, assesses fines, and takes other actions to ensure that employers address any violations Cal/OSHA identified.
Cal/OSHA issues citations and fines.
Employers can appeal the citations and fines.
Cal/OSHA's bureau of investigations separately investigates some accidents for potential criminal conduct and can refer them to local prosecutors.

Source: State law and Cal/OSHA policies and procedures.

When determining whether to conduct an on-site inspection, Cal/OSHA enforcement personnel assess a variety of factors. As Figure 2 shows, these factors vary substantially between complaints and accidents. One factor that is unique to complaints, for instance, is the source of the complaint: Cal/OSHA policy categorizes complaints as either *formal* or *non-formal* depending on who makes the complaint, and this categorization can affect whether Cal/OSHA conducts an on-site inspection.

State law prescribes time frames by which Cal/OSHA must investigate complaints from certain sources, as the text box shows. However, state law does not necessarily require Cal/OSHA to conduct on-site inspections of these complaints. Cal/OSHA has developed an alternative option for investigating complaints by which enforcement personnel send a letter to the employer outlining the complaint's allegations and requesting that the employer investigate them, address any hazards it identifies, and respond to Cal/OSHA in writing with the results of these efforts. Cal/OSHA refers to this option as an *investigation by letter* (letter investigation). Depending on the employer's response to Cal/OSHA's letter, letter investigations can still result in an on-site inspection.

State Law Requires Cal/OSHA to Respond to Complaints Within Certain Time Frames

If Cal/OSHA receives a complaint from an employee, an employee's representative, or certain others, it must investigate the complaint as soon as possible, but not later than:

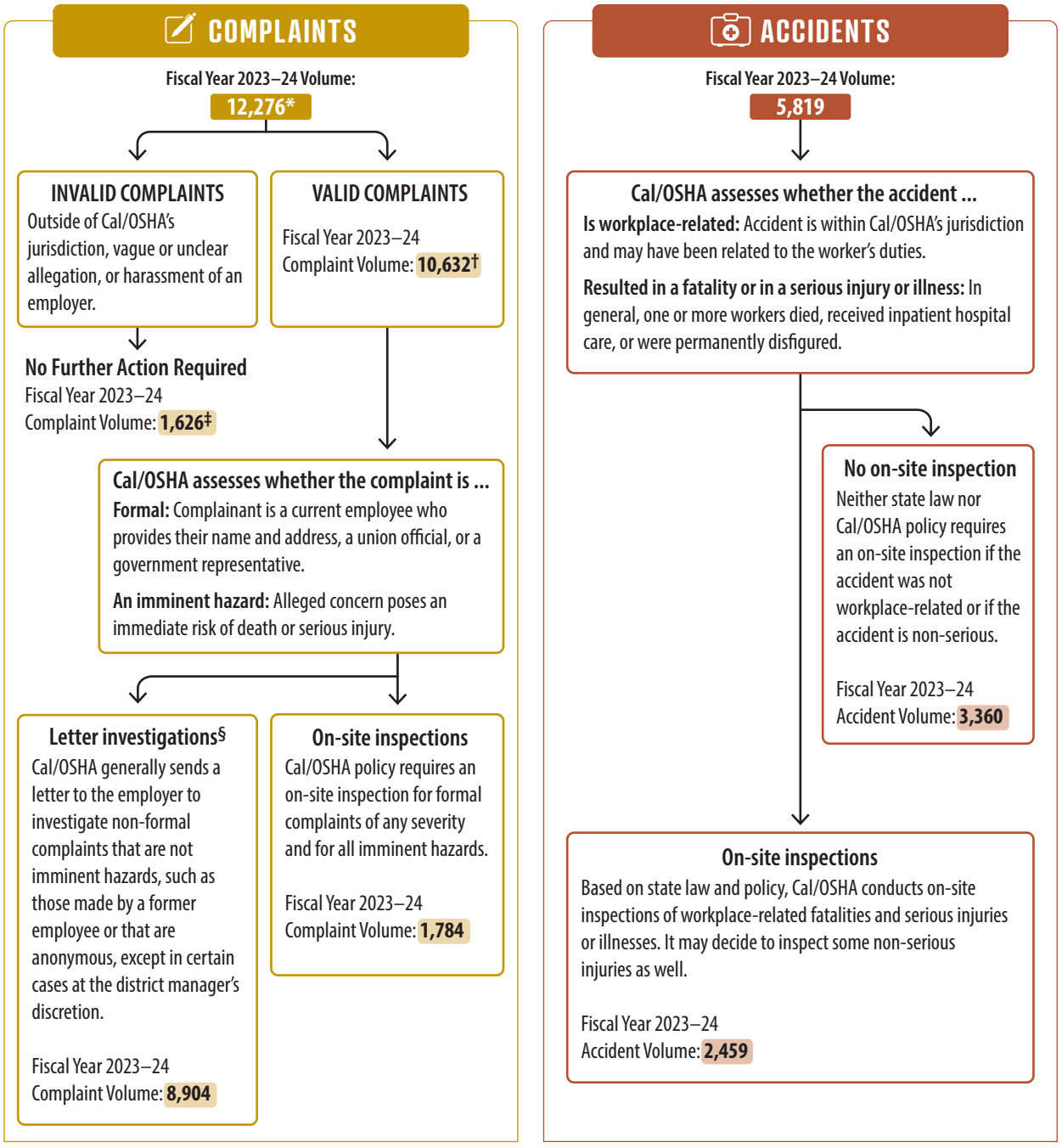
- **24 hours** for complaints from law enforcement or from a prosecutor.
- **3 working days** after receipt of a complaint alleging a serious violation.
- **14 calendar days** after receipt of a complaint alleging a non-serious violation.

A *serious violation* means that there is a realistic possibility that death or serious physical harm could result from the alleged hazard. All other complaints are deemed to allege *non-serious violations*.

Source: Labor Code section 6309.

When Cal/OSHA decides it is appropriate to do so, it conducts an on-site inspection to determine whether an employer has violated any workplace regulations and, if so, it issues citations and fines. In addition to responding to complaints and accidents, Cal/OSHA also conducts on-site inspections in other instances. For example, it conducts targeted or programmed inspections (proactive inspections) for certain industries, such as mining and tunneling, or according to certain indicators, such as when employers obtain permits for construction. Regardless of the type of on-site inspection that Cal/OSHA conducts, it gathers and documents evidence to determine whether any workplace violations exist and it issues citations within six months of the violations occurring. As Figure 3 shows, workplace violations generally fall into three categories that result in different fine amounts, and an inspection can result in multiple violations and fines. From fiscal years 2019–20 through 2023–24, about two-thirds of Cal/OSHA's on-site inspections resulted in at least one fine.

Figure 2
Cal/OSHA's Intake Processes for Complaints and Accidents Involve Weighing Different Factors to Determine Whether an Inspection is Necessary


COMPLAINTS
Fiscal Year 2023–24 Volume:
12,276*
INVALID COMPLAINTS
Outside of Cal/OSHA's jurisdiction, vague or unclear allegation, or harassment of an employer.
VALID COMPLAINTS
Fiscal Year 2023–24 Complaint Volume: 10,632†
No Further Action Required
Fiscal Year 2023–24 Complaint Volume: 1,626‡
Cal/OSHA assesses whether the complaint is ...
Formal: Complainant is a current employee who provides their name and address, a union official, or a government representative.
An imminent hazard: Alleged concern poses an immediate risk of death or serious injury.
Letter investigations§
Cal/OSHA generally sends a letter to the employer to investigate non-formal complaints that are not imminent hazards, such as those made by a former employee or that are anonymous, except in certain cases at the district manager's discretion.
Fiscal Year 2023–24 Complaint Volume: 8,904
On-site inspections
Cal/OSHA policy requires an on-site inspection for formal complaints of any severity and for all imminent hazards.
Fiscal Year 2023–24 Complaint Volume: 1,784
ACCIDENTS
Fiscal Year 2023–24 Volume:
5,819
Cal/OSHA assesses whether the accident ...
Is workplace-related: Accident is within Cal/OSHA's jurisdiction and may have been related to the worker's duties.
Resulted in a fatality or in a serious injury or illness: In general, one or more workers died, received inpatient hospital care, or were permanently disfigured.
No on-site inspection
Neither state law nor Cal/OSHA policy requires an on-site inspection if the accident was not workplace-related or if the accident is non-serious.
Fiscal Year 2023–24 Accident Volume: 3,360
On-site inspections
Based on state law and policy, Cal/OSHA conducts on-site inspections of workplace-related fatalities and serious injuries or illnesses. It may decide to inspect some non-serious injuries as well.
Fiscal Year 2023–24 Accident Volume: 2,459

Source: State law, Cal/OSHA policies and procedures, and OSHA Information System (OIS) data.

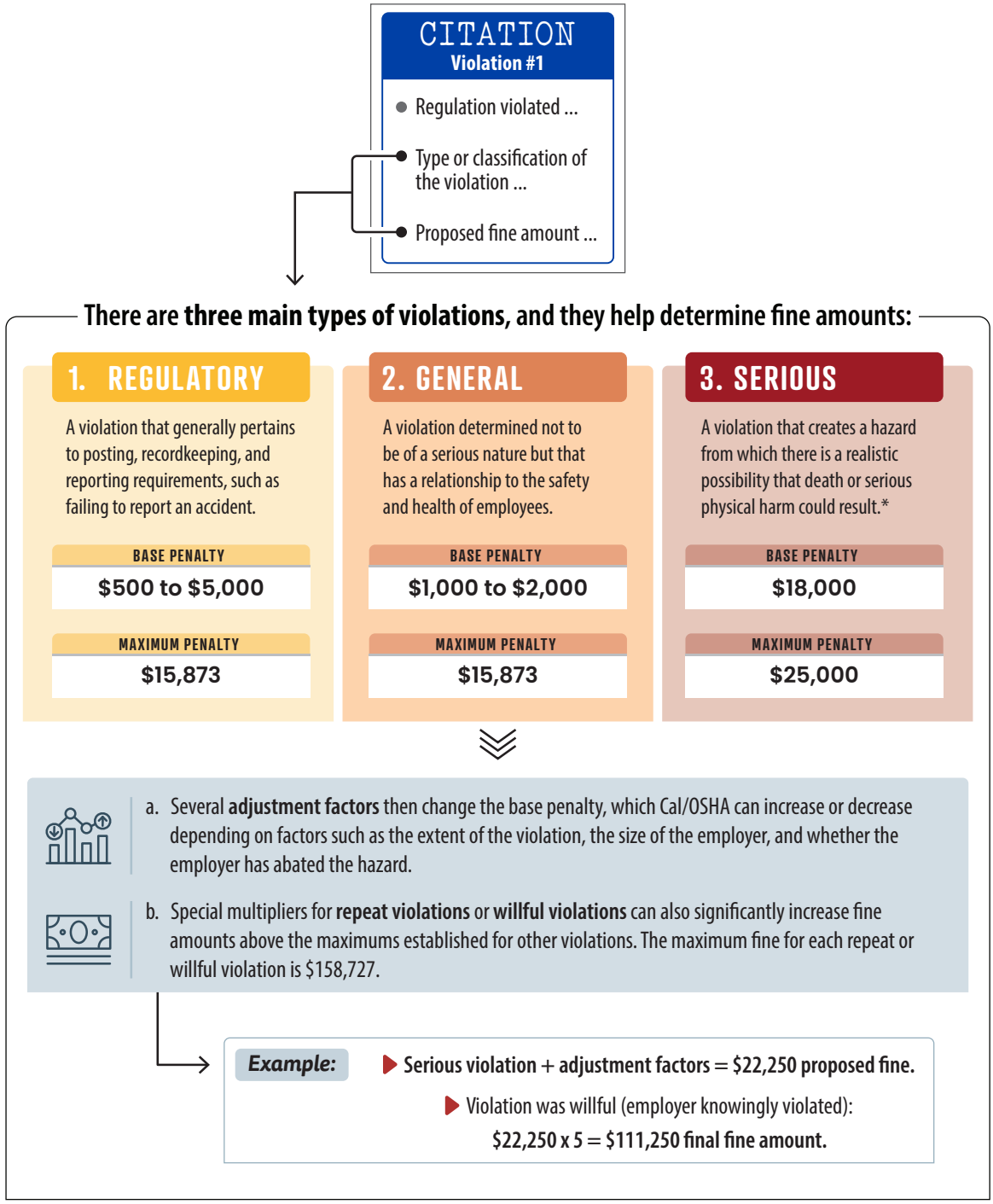
* Of the 12,276 complaints received in fiscal year 2023–24, Cal/OSHA deemed 10,632 as valid, 1,626 as invalid, and did not categorize the remaining 18 complaints, of which it performed on-site inspections for two of these uncategorized complaints.

† Cal/OSHA conducted both a letter investigation and an on-site inspection for 133 of the valid complaints it received, and we included these complaints in both categories. Further, Cal/OSHA did not conduct either a letter investigation or an on-site inspection for 77 of the valid complaints it received.

‡ Of the 1,626 complaints Cal/OSHA deemed as invalid, it nevertheless conducted either a letter investigation, an on-site inspection, or both for 30 of these complaints. We did not include these 30 complaints in our counts of letter investigations or on-site inspections.

§ Letter investigations can be followed by on-site inspections depending on the employer's response to Cal/OSHA's letter.

Figure 3
Cal/OSHA's Citations Include the Type of Violation and the Fine Amount


CITATION
Violation #1
Regulation violated ...
Type or classification of the violation ...
Proposed fine amount ...
There are three main types of violations, and they help determine fine amounts:
1. REGULATORY
A violation that generally pertains to posting, recordkeeping, and reporting requirements, such as failing to report an accident.
BASE PENALTY
$500 to $5,000
MAXIMUM PENALTY
$15,873
2. GENERAL
A violation determined not to be of a serious nature but that has a relationship to the safety and health of employees.
BASE PENALTY
$1,000 to $2,000
MAXIMUM PENALTY
$15,873
3. SERIOUS
A violation that creates a hazard from which there is a realistic possibility that death or serious physical harm could result.*
BASE PENALTY
$18,000
MAXIMUM PENALTY
$25,000
a. Several adjustment factors then change the base penalty, which Cal/OSHA can increase or decrease depending on factors such as the extent of the violation, the size of the employer, and whether the employer has abated the hazard.
b. Special multipliers for repeat violations or willful violations can also significantly increase fine amounts above the maximums established for other violations. The maximum fine for each repeat or willful violation is $158,727.
Example:
Serious violation + adjustment factors = $22,250 proposed fine.
Violation was willful (employer knowingly violated):
$22,250 x 5 = $111,250 final fine amount.

Source: State law, Cal/OSHA policies and procedures, and case files.

* State law defines *serious physical harm* as any workplace injury or illness that results in inpatient hospitalization for purposes other than medical observation; the loss of any member of the body; any serious degree of permanent disfigurement; or impairment sufficient to cause a part of the body or the function of an organ to become permanently and significantly reduced in efficiency on or off the job, such as, depending on the severity, crushing injuries, respiratory illnesses, or broken bones.

Upon receiving a citation from Cal/OSHA, an employer has 15 working days to appeal the citation or else it becomes final. Federal OSHA reported that in fiscal year 2022–23, employers appealed nearly half of all citations. If the employer appeals, the case then enters a process largely overseen by the Occupational Safety and Health Appeals Board (appeals board), which is a three-member, quasi-judicial body within DIR that is independent from Cal/OSHA. During this process, Cal/OSHA and the employer can negotiate a *settlement agreement*, which is an order signed by an administrative law judge that finalizes the case and the terms of any violations and fines. If the parties do not reach an agreement, the appeals board provides an opportunity for a formal hearing and issues a final decision. Hearings are relatively rare: for example, according to federal OSHA, the appeals board closed nearly 2,300 appealed cases during fiscal year 2022–23 but oversaw fewer than 100 hearings that year.

The Joint Legislative Audit Committee requested that we evaluate Cal/OSHA's oversight and enforcement efforts, including how it handles complaints and assesses fines. As the text box shows, we reviewed 60 case files that form the basis of our work in several report sections.

We Reviewed a Total of 60 Case Files

Our selection consisted of:

45 complaints

- 30 complaints without an on-site inspection.
  - 6 invalid complaints
  - 24 letter investigations
- 15 complaints with an on-site inspection.

15 accidents

- 7 accidents without an on-site inspection.
- 8 accidents with an on-site inspection.

Source: Selected case files covering our audit period of fiscal years 2019–20 through 2023–24.

Cal/OSHA Did Not Inspect Some Complaints and Accidents, Despite Evidence That an Inspection May Have Better Protected Workers

Key Points

- We questioned Cal/OSHA's rationale for deciding not to inspect complaints in nine of the 30 cases we reviewed because the case files lacked evidence to support that Cal/OSHA had complied with its policies for making these decisions. In at least five additional complaints we reviewed, Cal/OSHA followed its policies in deciding to investigate by letter rather than inspect on-site, but the circumstances of the cases, such as observable hazards or a history of complaints, suggested that inspections may have benefited workers more than the letter investigations did.

- Cal/OSHA often lacked assurance that employers had addressed the hazards alleged in complaints. In 15 of 24 letter investigations we reviewed, Cal/OSHA closed complaint cases without receiving or documenting sufficient evidence to support that the employer took steps to improve worker safety. Further, in 11 of the 24 letter investigations, employers did not respond in a timely manner—in two cases taking more than 50 days to respond—resulting in Cal/OSHA having limited assurance that employers had taken appropriately swift action to protect their workers.

- In six of the seven uninspected accident cases we reviewed, the case files lacked documentation to support Cal/OSHA's decision not to inspect. In one case, a worker suffered a laceration that resulted in surgery and an overnight hospital stay, but the case file did not contain any explanation for why the injury did not warrant an inspection. In addition, although Cal/OSHA has broad statutory authority to inspect accidents, state law and Cal/OSHA's policies require inspections of only fatalities or cases with the most severe injuries, meaning that Cal/OSHA may miss opportunities to correct workplace violations that cause less severe injuries—such as a skull fracture that rendered a worker unconscious but did not necessarily require inpatient hospital care—or that pose ongoing risks to workers.

Cal/OSHA Did Not Always Sufficiently Document Its Reasons for Deciding Not to Perform On-Site Inspections of Complaints

There are two ways in which Cal/OSHA may handle a complaint without conducting an on-site inspection: Cal/OSHA might determine that the complaint is invalid—if, for example, the complaint does not allege a workplace violation or if it is outside of Cal/OSHA's jurisdiction—or Cal/OSHA may decide to investigate a valid complaint by sending a letter to the employer. Figure 2 in the Introduction describes Cal/OSHA's process for making these determinations. During fiscal year 2023–24, Cal/OSHA classified 13 percent of the complaints it received as invalid and investigated 82 percent of the valid complaints it received with a letter instead of an on-site inspection.

Letter Investigations Have Benefits and Drawbacks Compared to On-Site Inspections

Potential benefits of letter investigations:

- Can be an efficient way for Cal/OSHA to respond to less serious hazards.
- Allows Cal/OSHA to interact with more employers about safety and health concerns.
- Can result in employers addressing hazards more quickly.

Potential drawbacks of letter investigations:

- Cal/OSHA may miss the opportunity to observe and address hazards that are not specifically included in the complaint.
- Employers essentially investigate themselves, which increases the risk that the hazard may remain uncorrected.
- Letter investigations cannot include citations or fines, which only result from on-site inspections.

Source: Cal/OSHA policies and procedures and interviews with Cal/OSHA managers.

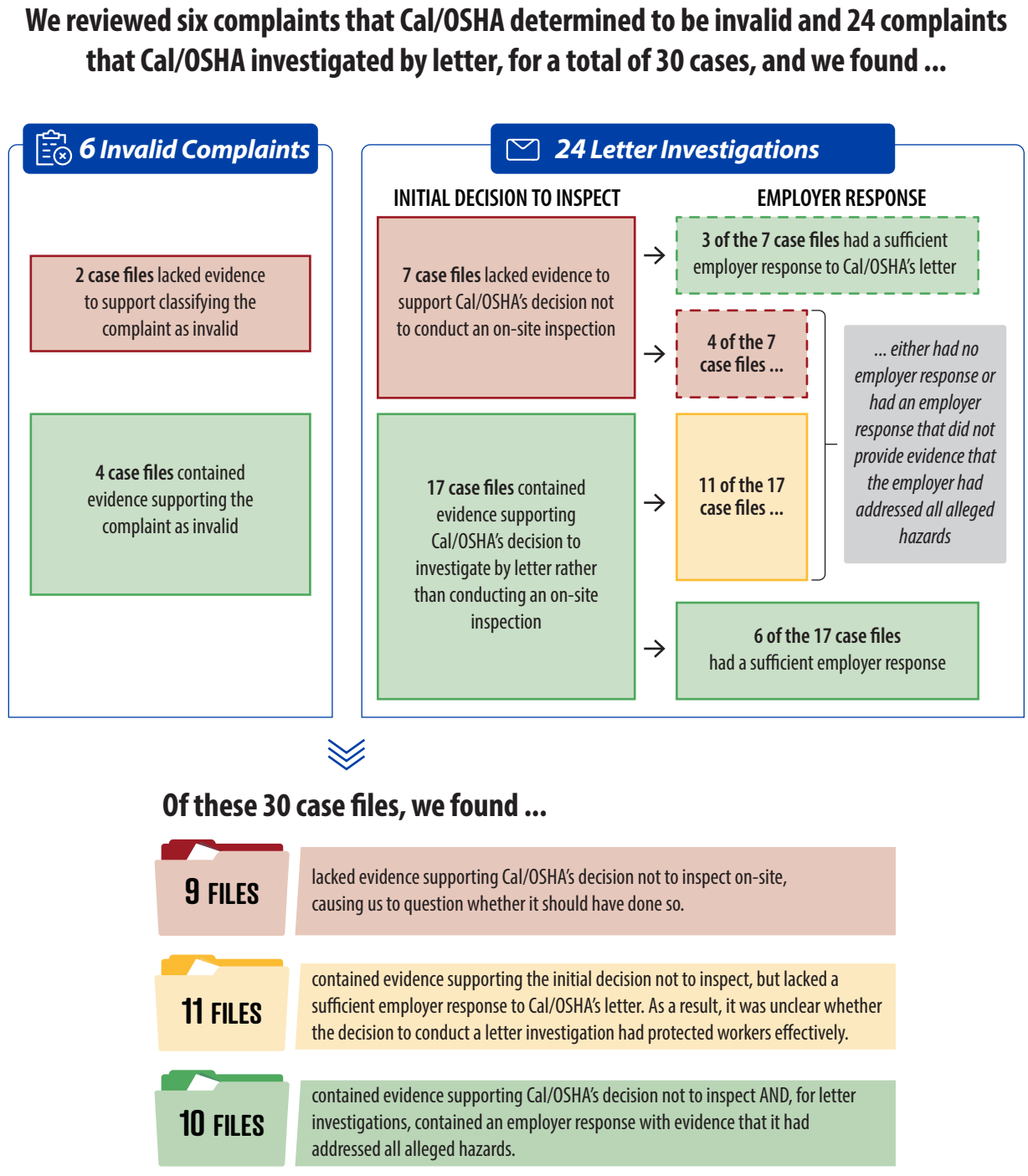
Although there are benefits to letter investigations, as the text box outlines, letter investigations are not a substitute for on-site inspections. Cal/OSHA policy acknowledges this trade-off by stipulating situations in which letter investigations cannot be used, such as when a complaint alleges an immediate risk of death or serious physical harm.

In Nine Cases, Cal/OSHA Lacked Evidence to Support Its Decision Not to Inspect On-Site

To evaluate Cal/OSHA's reasoning for deciding not to conduct on-site inspections of complaints, we reviewed 30 case files for complaints that Cal/OSHA did not inspect: six complaints that it classified as invalid and 24 complaints that it found valid but investigated with a letter. We compared Cal/OSHA's decision-making in these cases to its internal policies that govern its complaint evaluation and documentation. Figure 4 details our conclusions. We question Cal/OSHA's rationale for deciding not to inspect complaints in nine of the 30 cases—two of the six invalid cases and seven of the 24 letter investigations—because the case files lacked evidence to support that Cal/OSHA had complied with its own policies for making these decisions. These nine complaints included hazards that ranged in severity from allegations of impalement risks and unguarded machinery to allegations of poor ventilation and contaminated drinking water. However, in each case, an on-site inspection could have helped ensure that the workplace was safe. Further, by not inspecting these cases, Cal/OSHA missed opportunities to hold employers accountable through citations and fines.

In one case that we depict in Figure 5, a worker was hanging onto the side of a moving construction vehicle in a manner that risked the worker falling off and potentially being hit by oncoming traffic. Cal/OSHA considered the complaint to be outside of its jurisdiction and therefore invalid, so Cal/OSHA closed the case without investigating. However, the case file included only minimal explanation of Cal/OSHA's reasoning, and our assessment of the complaint led us to conclude that it was likely within Cal/OSHA's jurisdiction. The case file also did not include evidence that the district office had consulted with the legal unit to confirm that Cal/OSHA did not have jurisdiction in this case, even though Cal/OSHA's policy states that district offices should do so if they have questions about jurisdiction at a particular worksite. As a result of its determination that the complaint was invalid, Cal/OSHA did not follow up with the employer at all and hazards may have conceivably continued to pose risks to workers at that worksite.

Figure 4
Two-Thirds of the Uninspected Complaints We Reviewed Lacked Either Evidence Supporting the Initial Decision Not to Inspect or a Sufficient Employer Response


We reviewed six complaints that Cal/OSHA determined to be invalid and 24 complaints that Cal/OSHA investigated by letter, for a total of 30 cases, and we found ...
6 Invalid Complaints
2 case files lacked evidence to support classifying the complaint as invalid
4 case files contained evidence supporting the complaint as invalid
24 Letter Investigations
INITIAL DECISION TO INSPECT
EMPLOYER RESPONSE
7 case files lacked evidence to support Cal/OSHA's decision not to conduct an on-site inspection
3 of the 7 case files had a sufficient employer response to Cal/OSHA's letter
4 of the 7 case files ...
17 case files contained evidence supporting Cal/OSHA's decision to investigate by letter rather than conducting an on-site inspection
11 of the 17 case files ...
... either had no employer response or had an employer response that did not provide evidence that the employer had addressed all alleged hazards
6 of the 17 case files had a sufficient employer response
Of these 30 case files, we found ...
9 FILES
lacked evidence supporting Cal/OSHA's decision not to inspect on-site, causing us to question whether it should have done so.
11 FILES
contained evidence supporting the initial decision not to inspect, but lacked a sufficient employer response to Cal/OSHA's letter. As a result, it was unclear whether the decision to conduct a letter investigation had protected workers effectively.
10 FILES
contained evidence supporting Cal/OSHA's decision not to inspect AND, for letter investigations, contained an employer response with evidence that it had addressed all alleged hazards.

Source: Case files and Cal/OSHA policies and procedures.

Figure 5
Cal/OSHA Classified a Complaint as Invalid and Took No Further Action, but the Complaint Was Likely Valid and Within Its Jurisdiction

A union representative submitted a complaint and video files alleging a serious hazard:
Two workers riding on heavy machinery with no safety belts.
One worker hanging onto the side while vehicles pass in the opposite direction, creating a risk that the worker could fall and be hit by oncoming traffic.

How Cal/OSHA likely *should have* classified it:

VALID

WITHIN JURISDICITON

Reasoning: Workers appeared to be using a jobsite vehicle; Title 8 regulations exist that apply to jobsite vehicles, including using seat belts and protecting workers from traffic.

ON-SITE INSPECTION

How Cal/OSHA *actually* classified it:

INVALID

NO JURISDICTION

Stated rationale in case file: "On a city street."

Issues: May have misinterpreted the relevant regulations and did not explain in any detail why they did not apply.

CASE CLOSED
(no action taken)

▶ The current district manager at this office, who was not there at the time, told us that this complaint should have been classified as *valid* and inspected on-site as an imminent hazard.

Source: Case file, regulations, Cal/OSHA policies and procedures, and interviews with the current district manager.

Similarly, as we show in Figure 6, Cal/OSHA investigated a heat-related complaint by sending a letter to the employer when policy required it to have inspected on-site. According to the current regional manager, the rationale documented in the case file for not inspecting—*manager discretion*—had no basis in Cal/OSHA policy and would not have been an option based on the specifics of the complaint. Moreover, the regional manager stated that because the complainant referenced a heat illness, the district office should have completed an accident report and followed the inspection procedures under Cal/OSHA's heat illness prevention special emphasis program. Because it did not conduct an on-site inspection, Cal/OSHA may have missed opportunities to issue citations, assess fines, and ensure that the employer corrected the hazard—a hazard that had already generated two complaints and resulted in a worker receiving emergency medical treatment.

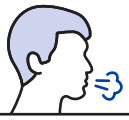
Managers explained that understaffing sometimes contributed to their decisions to investigate with a letter rather than inspect on-site. For example, in one case that Cal/OSHA categorized as a *serious hazard*—in which a complainant alleged that the employer was operating a machine without proper guards—the district manager told us that if the district office had been fully staffed, he would have assigned the complaint for inspection. In the two-month span of time during which the district office received the complaint, the office fielded 470 total complaints, accidents, and referrals and likely had vacancies in about half of its 15 total staff positions. Nevertheless, none of the case files we reviewed documented understaffing as a factor in the district office's decision not to inspect a complaint, and the absence of that rationale contributes to a lack of transparency in Cal/OSHA's decision-making practices.

Another possible cause for Cal/OSHA's decisions not clearly aligning with its own policy requirements is that in certain of the nine cases, these decisions may have potentially complied with policy, but district offices did not document evidence to demonstrate their compliance. In our follow-up discussions with regional and district managers about the case files, some of the managers agreed that Cal/OSHA should have inspected certain complaints we reviewed. However, other managers indicated that their offices' decisions had complied with policy. For instance, one manager told us that a complainant must have agreed to Cal/OSHA conducting a letter investigation instead of an on-site inspection, which would have made Cal/OSHA's decision not to inspect that case compliant with policy. Nevertheless, the case file did not contain any evidence of the complainant's agreement. In another case we reviewed, the district manager told us that the complainant had not been an official union representative of employees at the worksite, which meant that Cal/OSHA policy did not require an inspection. However, the district office did not document or explain these details about the complainant in the case file, raising questions about their validity. Currently, Cal/OSHA's policies do not require district offices to explain their reasoning in detail—such as how their decisions align with each relevant component of policy—when they decide not to inspect. Cal/OSHA leadership told us that the division is in the process of rewriting its policies to ensure that enforcement personnel explain in detail their reasons for not conducting on-site inspections of complaints.

Figure 6
Cal/OSHA Investigated a Complaint by Letter When Its Policies Required an On-Site Inspection

A worker made a complaint to Cal/OSHA alleging that ...

The employer had failed to fix the air conditioning system, meaning that the temperature of the kitchen in which the employee worked **exceeded 90 degrees** at times.



Ventilation in the kitchen was poor, putting employees at risk of **breathing smoke**.

The worker may have suffered **heat illness** and was taken to the ER by ambulance.

Two different Cal/OSHA policies required an on-site inspection:

1. Cal/OSHA **should always inspect on-site when the complainant is a current employee** who provides their name and address and the **hazard is serious**.
   - The complainant in this case appeared to be a current employee who provided a name and address.
   - Cal/OSHA categorized the alleged hazards as serious.
2. Cal/OSHA **should inspect on-site all indoor heat-related complaints** when the complainant is a current employee who provides their name and address.
   - The complaint referenced heat-related concerns in an indoor environment.

In addition, Cal/OSHA received a similar complaint about the same employer's air conditioning system a few months earlier.

- Cal/OSHA sent a letter to the employer instead of inspecting on-site. According to case records, **the employer had yet to respond** to that letter to explain how they had addressed the hazard.

Despite these factors, Cal/OSHA sent the employer another letter rather than inspecting on-site.

Rationale stated in case file:
"[Manager] discretion"

The employer **did not provide evidence**, such as repair invoices, **to show that they corrected the hazards** when it responded to Cal/OSHA's second letter investigation.

Source: Complaint case files and related records and Cal/OSHA policies and procedures.

In at Least Five Cases, Cal/OSHA Followed Its Policies in Deciding to Investigate by Letter, but Those Policies Are Flawed

In at least five of the 24 letter investigation cases we reviewed, Cal/OSHA followed its policies in deciding not to inspect on-site, but there were factors indicating that inspections may have benefited workers more than the letter investigations did. For example, these factors included complaints that alleged a worker injury, complaints with observable hazards that could have posed harm to workers, and a complaint in which the employer had a history of a previous complaint.

The text box describes one of these complaints. Cal/OSHA's decision not to inspect aligned with policy because the complainant submitted the complaint anonymously. However, whether a complaint is anonymous should not be a critical determining factor in whether to conduct an on-site inspection because complainants may have legitimate reasons for not wanting to identify themselves, such as a fear of employer retaliation.

Example of a Complaint for Which an On-Site Inspection May Have Been Beneficial

An employee submitted a complaint to Cal/OSHA about an employer that operated a warehouse.

- **Main hazards alleged:** Employees use machinery unsafely, such as by standing on the tops of forklifts to access inventory. Employees are not required to wear steel-toed boots or safety vests.
- **Additional context:** The complaint mentioned an employee who broke a leg while moving boxes. Cal/OSHA had also received a previous complaint related to the employer's forklift safety and had not inspected it on-site.
- **Cal/OSHA's documented reasons for not inspecting:** The complainant was anonymous, making the complaint *non-formal*, and thus not requiring inspection.
- **Outcome:** Cal/OSHA sent a letter to the employer. The employer responded that the hazards were not present, but it did not provide supporting documentation for that claim, such as photographs or safety policies.

Source: Complaint case file.

For deciding whether to investigate complaints by letter or to inspect on-site, Cal/OSHA's policies generally place more emphasis on the source of the complaint than they do on other factors, such as the alleged hazards, the employer's history, and the potential benefits of an on-site inspection relative to the specific circumstances of the complaint. Cal/OSHA's data also indicate as much: from fiscal years 2019–20 through 2023–24, it conducted inspections of nearly two-thirds of the valid complaints that it classified as *formal*—for example, if the complainant was a current employee who provided Cal/OSHA with their name and address. By contrast, it conducted inspections of only about one-third of the valid complaints that it classified as alleging an *imminent* or *serious hazard*. In other words, the source of the complaint has a larger impact on Cal/OSHA's decision about whether to inspect on-site than does the severity of the allegations. In three of the cases we reviewed, Cal/OSHA did not inspect the complaint primarily because the complainant was anonymous, and the case file did not demonstrate whether other circumstances of the complaint made it suitable for a letter investigation. In two other cases, the complainant apparently agreed to a letter investigation, in which case Cal/OSHA's policy allows district offices to classify the complaints as *non-formal* even if the alleged hazards may otherwise have warranted an inspection. Changing its policies to require staff to more explicitly weigh factors in addition to the source of the complaint would help Cal/OSHA better justify its choice to investigate with a letter and might also lead to Cal/OSHA inspecting more employers on-site when doing so could benefit workplace safety.

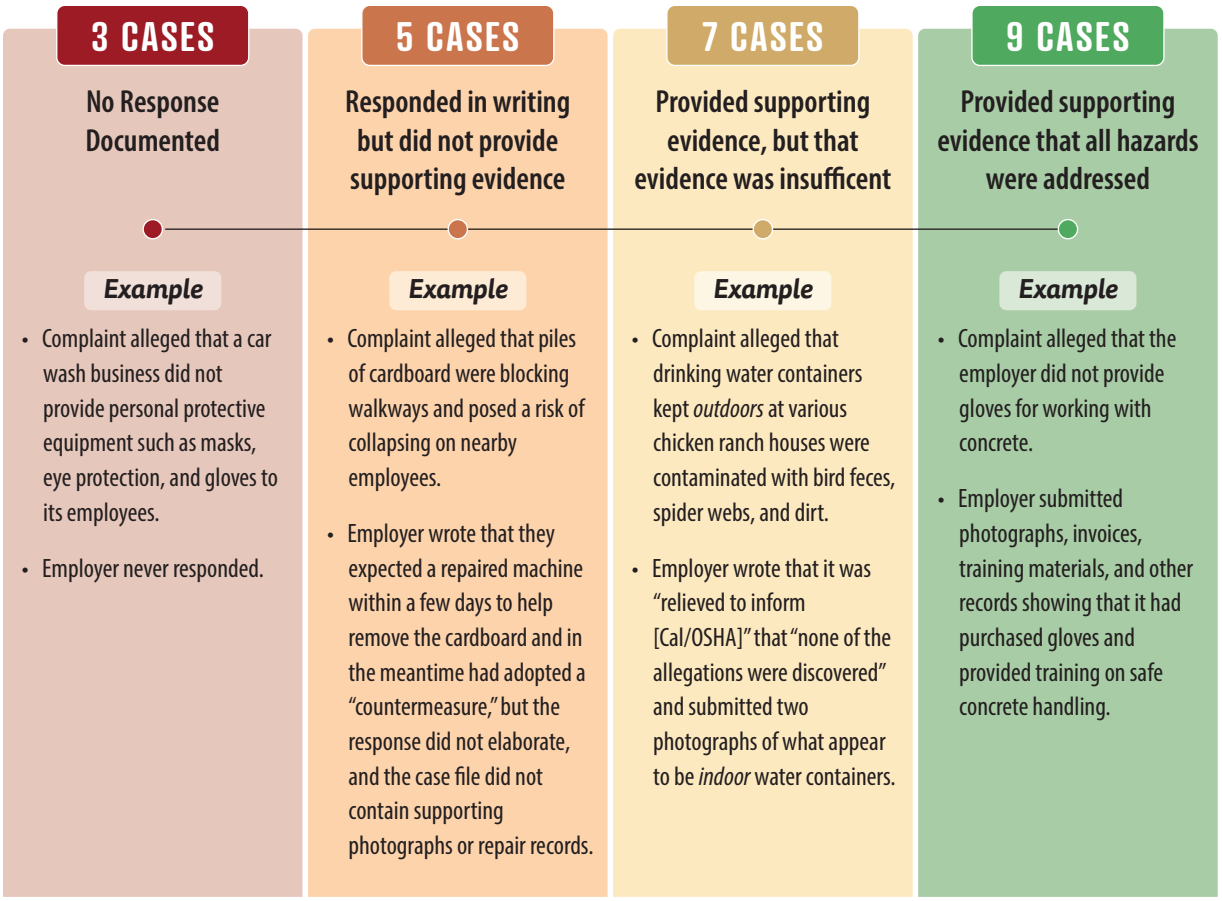
Cal/OSHA leadership agreed that factors like the severity of a complainant's allegations are important for enforcement personnel to assess and stated that personnel already consider severity when evaluating complaints. They told us that Cal/OSHA is in the process of rewriting its policies and procedures for clarity and to ensure that enforcement personnel work toward the goal of conducting on-site inspections of complaints that allege serious hazards, regardless of whether the complaint is formal or non-formal.

For Complaints Investigated by Letter, Cal/OSHA Often Did Not Require Evidence That Employers Had Addressed All Alleged Hazards

When Cal/OSHA conducts a letter investigation, the district office must request a written response from the employer within a specified time frame and document that this response is satisfactory. Cal/OSHA's policy states that if the response is not satisfactory, the office should inspect the employer on-site. However, as Figure 7 shows, employers' responses to the letter investigations we reviewed varied significantly in quality, yet Cal/OSHA closed all these cases without inspecting on-site. For instance, Cal/OSHA closed three of the 24 cases even though the case files did not include a response from the employer addressing the concerns raised. Overall, in 15 of 24 letter investigations, Cal/OSHA closed complaint cases without clear supporting evidence that the employer addressed all the alleged hazards.

Cal/OSHA's policy for handling letter investigations is unclear about what constitutes a satisfactory employer response. For example, one section of the policy requires that Cal/OSHA's letter inform the employer that the employer's response must describe the results of its investigation, explain corrective actions taken, and include evidence that documents hazard correction, such as photographs, video, or invoices. However, the section of the policy that relates to Cal/OSHA evaluating the employer's response does not specify that the employer must submit evidence, and it instead defines a *satisfactory* response as "one which indicates that the employer performed an investigation of the complaint items and either determined that a hazard was present and undertook appropriate corrective actions, or determined that no hazard was present." As a result of this vagueness in policy, the district and regional managers we spoke with shared different opinions about what the policy required. For instance, one regional manager told us that Cal/OSHA's letter to the employer always requests that the employer include in its response documentation to support its corrective measures but that this documentation is *preferred* rather than absolutely *required*. Another district manager stated that for one case we reviewed—one for which the employer's response did not contain any supporting documents—he considered the response satisfactory based on his understanding of the alleged hazards and the type of worksite in which they occurred.

Figure 7
Cal/OSHA Closed Some Letter Investigations Without Sufficient Evidence That the Employers Had Addressed All Alleged Hazards


In the 24 letter investigations we reviewed, there was a wide range of quality in employers' responses to Cal/OSHA, in part because Cal/OSHA's policy about what constitutes a satisfactory employer response is unclear.
3 CASES
No Response Documented
Example
• Complaint alleged that a car wash business did not provide personal protective equipment such as masks, eye protection, and gloves to its employees.
• Employer never responded.
5 CASES
Responded in writing but did not provide supporting evidence
Example
• Complaint alleged that piles of cardboard were blocking walkways and posed a risk of collapsing on nearby employees.
• Employer wrote that they expected a repaired machine within a few days to help remove the cardboard and in the meantime had adopted a "countermeasure," but the response did not elaborate, and the case file did not contain supporting photographs or repair records.
7 CASES
Provided supporting evidence, but that evidence was insufficent
Example
• Complaint alleged that drinking water containers kept *outdoors* at various chicken ranch houses were contaminated with bird feces, spider webs, and dirt.
• Employer wrote that it was "relieved to inform [Cal/OSHA]" that "none of the allegations were discovered" and submitted two photographs of what appear to be *indoor* water containers.
9 CASES
Provided supporting evidence that all hazards were addressed
Example
• Complaint alleged that the employer did not provide gloves for working with concrete.
• Employer submitted photographs, invoices, training materials, and other records showing that it had purchased gloves and provided training on safe concrete handling.

Source: Case files, Cal/OSHA policies and procedures, and interviews with Cal/OSHA officials.

Although some of the complaints that we summarize in Figure 7 alleged hazards that did not appear to be dangerous—for example, pest control issues or unreliable running water for hand-washing—others described situations with substantial risks for injury or illness. In one case, a complainant alleged that a beverage manufacturer was operating a machine with the guard doors open, which the Cal/OSHA district office determined was a serious hazard. An inspector at the district office requested from the employer and included in the case file several photographs of the machine. However, the photographs were unclear—for example, some were not close enough to the machine to see it in detail—and the case file did not include a note from the employer or inspector explaining the photographs. The district manager told us that the inspector who evaluated the employer's response was newly hired and that if the district office had more staff, it could have better trained the inspector to request clearer photographs. When Cal/OSHA does not ensure that employers' responses are complete and supported with evidence that the employers' assertions are true regarding the alleged hazards and their correction, it reduces assurances that letter investigations fully mitigated the potential harms to workers. Even for complaints that allege less serious hazards, ensuring that employers appropriately responded to these hazards would help Cal/OSHA hold employers accountable for workplace safety and demonstrate that it is responsive to workers' concerns.

Cal/OSHA policy includes two additional mechanisms that are intended to help district offices minimize the risk that employers do not correct hazards, but these mechanisms have flaws. First, district offices are supposed to send a letter to the complainant about the employer's response to the letter investigation. The template for this letter invites complainants to contact Cal/OSHA if they do not agree with the findings and states that if Cal/OSHA does not hear from the complainant, it will assume that the employer adequately corrected the hazards. However, relying on further response from the complainant to identify ongoing hazards places significant burden on the complainant and does not work for cases with anonymous complainants. Second, Cal/OSHA policy allows, but does not require, the district manager to select a specified percentage of satisfactory employer responses to inspect on-site to verify that the employer corrected the hazards. A 2024 workload study of Cal/OSHA's inspector positions pointed out that these types of inspections are important because the chance of them occurring encourages compliance from employers, and the study found that Cal/OSHA had an unmet need for hundreds more of these inspections annually. Several district managers indicated that they lacked the staff necessary to conduct these follow-up inspections given the higher-priority inspections they had to handle. We discuss understaffing more fully later in this report.

In addition to requiring written responses from employers who receive letter investigations, Cal/OSHA requires that employers respond in a timely manner—within five working days of receiving a letter for complaints alleging serious hazards and within 14 calendar days for non-serious complaints.[2] Employers did not submit timely responses in 11 of the 24 letter investigations we reviewed, reducing assurances that they had taken prompt action to protect their workers. Three employers among

[2] We also assessed Cal/OSHA's timeliness in sending the initial letters and found that in 19 of 24 letter investigations, Cal/OSHA sent letters to employers in a timely manner, and the five that were late were all less than a week overdue.

those 11 cases did not respond at all, and two others took more than 50 days to respond. Managers shared that the primarily paper-based case management system, coupled with too few office technicians, made it difficult to track letter investigation deadlines or to know for certain the date that the employer received Cal/OSHA's letter in the mail—or if they received it at all. However, one district manager told us that the office sends letters via email to have a record of the date that the employer received the letter. Calling employers before sending letters may also help: Of the five letter investigations we reviewed involving serious hazards—those for which policy requires phone contact with the employer—each employer responded within the deadlines.

Cal/OSHA Did Not Sufficiently Document Its Decisions Not to Inspect Some Accidents We Reviewed

Cal/OSHA's process for determining whether to conduct an on-site inspection of reported workplace accidents differs from its process for complaints. As the text box describes, state law requires that Cal/OSHA investigate certain accidents—unless it determines that an investigation is unnecessary and explains its reasoning—and gives it broad authority to investigate others. Whereas Cal/OSHA conducts investigations by letter for some complaints, Cal/OSHA does not do so for accidents, which means that it either conducts an on-site inspection of accidents or it takes no further action.

State Law Gives Cal/OSHA Broad Authority for Conducting Accident Investigations

1. Cal/OSHA **shall investigate** the causes of any employment accident that is **fatal** to one or more employees or that results in a **serious injury or illness**, or a serious exposure, unless it determines that an investigation is unnecessary. If the division determines that an investigation is unnecessary, it shall summarize the facts indicating so and the means by which the facts were determined.
    a. *State law defines "serious injury or illness" to include injuries that require **inpatient hospitalization, for other than medical observation or diagnostic testing**, or in which an employee suffers ... serious permanent disfigurement.*
2. Cal/OSHA **may investigate** the causes of **any other industrial accident or occupational illness** which occurs within the state ...

[Emphasis added]

Source: Labor Code sections 6302 and 6313.

To determine whether Cal/OSHA documented logical reasons for not conducting on-site inspections of reported accidents, we selected for review seven uninspected accidents with injury descriptions that concerned us. In six of the seven cases we reviewed, the case files lacked documentation to support Cal/OSHA's decision not to inspect. These six cases included injuries and illnesses that ranged from apparent heat illnesses requiring emergency medical treatment to lacerations that required hospital care or even surgery. The text box on the following page describes two of these cases. When we spoke with district managers about these cases, they provided additional context—context that was not documented in the case files—for why the cases may not have warranted an inspection. For example, the district manager for the office that handled Case Example 1 told us that the worker appeared to have been wearing personal protective equipment, creating less reason to suspect that the employer violated safety regulations. However, the case file did not document this reasoning, which enforcement personnel could have done by, for example, explaining which safety regulations would have applied or by explaining how surgery and an overnight

Cal/OSHA Did Not Inspect Some Accidents, Even Though an Inspection May Have Helped Protect Workers

Examples of accidents reported to Cal/OSHA that it decided not to inspect:

Case Example 1: An employee suffered a laceration on his shin from a chainsaw, resulting in surgery, an overnight hospital stay, and six weeks of recovery.

- The case file merely cited Labor Code section 6313, which we show in the previous text box, as reason not to conduct an on-site inspection. However, the injury appeared to meet the definition of *serious* in state law, and the file did not include an explanation of why the injury was not considered *serious* or, if it was, why an inspection was unnecessary.

Case Example 2: An accident report stated than an employee was struck in the head by an object, resulting in a skull fracture that rendered the employee unconscious for five to ten minutes.

- The report referred to the injury as *serious* but stated that the employee was in the hospital for only nine hours, so there was no inspection. The case file referenced an outdated requirement and did not include medical records or other evidence to support that the injury did not meet the definition of *serious* in state law.

Source: Accident case files.

hospital stay did not constitute a serious injury. In Case Example 2, the district manager indicated that the worker had likely not been formally admitted for inpatient hospital care, meaning that state law did not consider the injury to be serious. Even so, the one-page case file referenced an outdated statutory requirement about the number of hours of hospital care and did not include any medical records as supporting evidence. By not inspecting cases such as these, Cal/OSHA may be missing opportunities to hold employers accountable for harm that their workers experience.

In two other cases, Cal/OSHA's policy for handling heat-related accidents appeared to require an on-site inspection, but Cal/OSHA did not conduct one. Cal/OSHA has a heat illness prevention special emphasis program (heat policy) that was active at the time of both accidents and generally requires on-site inspections of accidents that are related to heat illness. In one case we reviewed, the accident report listed the incident as "heat illness" and stated that the employee "became disoriented and vomited," "was reportedly 'in and out of consciousness,'" and had not had any water to drink that day—all of which align closely with indicators in the heat policy that would require an inspection. However, the case file did not document any consideration of the heat policy to support Cal/OSHA's decision not to inspect. Instead, the file noted that Cal/OSHA's reason for not inspecting was that the injury was not considered serious, because the worker was taken to the emergency room for observation only and was not formally admitted for inpatient hospital care. A senior safety engineer from the district office that handled the case also told us that the office had visited the worksite many times and knew from experience that the employer provides water for its workers. However, the senior safety engineer agreed that the heat policy requires on-site inspections of any suspected heat illnesses. Further, about four months after the accident occurred, a worker at the same worksite "collapsed from apparent heat exhaustion" and was taken by ambulance to a hospital.

Understaffing was one of the causes that contributed to the issues we identified. Every district manager we contacted regarding uninspected accidents stated that they were short-staffed and that this affected their ability to do their work. For instance, in Case Example 1 in the previous text box, even though the district manager provided context for why an inspection may not have been warranted, the district manager told us that limited staffing was also one reason the district office did not conduct an inspection. The district manager indicated that the office would like to inspect more

cases but lacks the staff to do so and must focus on the cases that have the highest impact on employee health and safety. We discuss Cal/OSHA's understaffing in more detail later in this report.

Nevertheless, Cal/OSHA should also make changes to its policies and processes to ensure that it conducts inspections of accidents whenever appropriate. Given Cal/OSHA's broad authority for inspecting accidents, we would have expected it to have guidelines for how to determine whether an on-site inspection of an accident is warranted and how to document the specific reasons for that determination. However, Cal/OSHA's policies do not specify any process for inspecting accidents that are not considered *serious* under state law. For example, one of its policies lists priorities for each type of inspection that Cal/OSHA may conduct, such as prioritizing inspections of *imminent hazard* complaints and fatal accidents above inspections of other types of complaints and accidents. However, this priority list does not mention inspecting accidents with non-serious injuries, even though these types of accidents may still reflect dangerous hazards that pose risks to workers. In one case file we reviewed, a fire captain reported to Cal/OSHA an accident involving an electric shock, but the district office processed the case as a complaint instead of an accident and conducted a letter investigation. According to the district manager, the district office processed the case as a complaint because the accident was non-serious—meaning that Cal/OSHA was not required to investigate it—but the office wanted to investigate anyway to ensure that the employer addressed the hazard. One reason that enforcement personnel may classify *accidents* as *complaints* just to investigate them further is because Cal/OSHA's complaint policies have more options and guidelines for investigating less serious hazards. For instance, Cal/OSHA's accident policies do not include guidelines for considering factors beyond the severity of the worker's injury when determining whether an inspection would be beneficial for workplace safety. In particular, the policies do not require personnel to consider the likelihood that an inspection could identify a workplace violation that poses risks to workers. Such guidelines would help Cal/OSHA inspect more accidents that fall below the high threshold in state law for mandatory investigations yet still represent a potential risk for workers.

Even for the process of simply determining whether state law requires accident investigations, Cal/OSHA policies contain little guidance about how district offices should document their reasons for not inspecting, such as whether district offices should include medical records as support, a practice that we found varied by case file. For example, in at least three cases we reviewed—such as the reported skull fracture that we describe as Case Example 2 in the text box earlier—workers had apparently received care at a hospital, but that care may not have been classified as *inpatient care*, raising questions about whether the injuries met the definition of *serious* in state law. One senior safety engineer told us that the district office relies on the hospital's determination about whether to admit a patient for inpatient treatment. Even so, none of those three case files included medical records or other supporting evidence that indicated whether the care provided was inpatient care, likely because Cal/OSHA policy does not require this type of documentation. In addition, the accident report forms in case files we reviewed often left room for only short phrases such as "[Labor Code section] 6313" or "no serious injury," rather than more detailed and helpful reasoning.

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When It Does Perform Inspections, Cal/OSHA's Process Has Critical Weaknesses

Key Points

- When Cal/OSHA did conduct on-site inspections, those inspections were not always thorough and effective. For example, Cal/OSHA enforcement personnel did not consistently document effective reviews of employers' injury and illness prevention programs (IIPP)—which provide key safeguards against dangerous hazards—nor did they always include detailed and legible notes from interviews they conducted with workers. In one fatal accident we reviewed, the case file included the employer's IIPP but did not contain any documentation that the inspector had evaluated it or its implementation, even though there were indications that an IIPP violation may have occurred.

- Cal/OSHA took weeks or even months to initiate some complaint and accident inspections, which can hinder its ability to gather relevant evidence and identify violations that have put workers at risk. In four of our 15 selected complaints, Cal/OSHA began the inspections after the deadlines in state law, ranging from about one week late to about two months late. In addition, Cal/OSHA initiated three non-fatal accident inspections we reviewed one month or more after the accidents had occurred.

Cal/OSHA's Inspections Varied in Their Thoroughness and Effectiveness

We reviewed 15 complaints that received an on-site inspection and found that the inspections did not always adhere to Cal/OSHA's policies for gathering, documenting, and organizing evidence. We also reviewed eight reports of accidents that Cal/OSHA inspected and found some of the same shortcomings. Figure 8 highlights our concerns.

For instance, Cal/OSHA's inspections did not consistently document thorough reviews of employers' safety programs as both law and policy mandate. State law requires every employer to establish, implement, and maintain an effective IIPP. The IIPP is a written plan intended to prevent injuries and illnesses by establishing methods to identify and correct hazards and by ensuring that employees comply with safe workplace practices. Every Cal/OSHA inspection is supposed to include an evaluation of the employer's IIPP, and 34 percent of on-site inspections that occurred during our audit period and resulted in a citation identified at least one IIPP-related violation. Evaluating an employer's IIPP and identifying related violations can be an important way to ensure that the employer's underlying safety culture and practices are effective at protecting workers and preventing injuries and illnesses. Figure 9 shows that despite the importance of thoroughly evaluating the IIPP, the case files we reviewed did not demonstrate that Cal/OSHA always did so.

Figure 8
Case Files Did Not Always Document That Cal/OSHA Had Followed Important Aspects of Its Inspection Process

Examples of inspection steps in Cal/OSHA's policies for which we identified deficiencies:

Evaluate the employer's IIPP and how well the employer is implementing that program, which ensures that employers maintain effective safety programs that protect their workers.

- Seven of the 15 complaint inspections we reviewed did not include any IIPP-related violations and lacked a complete IIPP evaluation in the case file, causing us to question whether the inspection may have overlooked potential violations.

Record audio of interviews or obtain signed statements when possible; otherwise, document legible interview notes. These steps help ensure that Cal/OSHA develops strong evidence to support the violations it identifies.

- Only one of the 15 complaint case files included audio recordings or a signed statement from an interviewee.
- Five of the 15 case files contained interview notes that were difficult to read, overly brief, undated, or unclear as to which individual made each statement.

Organize evidence and explain each element of a violation, which ensures that the violation is founded and is likely to withstand an appeal by the employer.

- In five of our 11 selected complaints that included citations, the relevant worksheets were incomplete, raising questions about whether Cal/OSHA had obtained sufficient evidence to support the violations.

Case files we reviewed involving **accident inspections** contained similar deficiencies.

Source: State law, Cal/OSHA policies and procedures, and case files.

Figure 9
Cal/OSHA Did Not Always Document Thorough Evaluations of Employers' Safety Programs, Missing Opportunities to Better Protect Workers

Every employer must implement an effective IIPP that includes several key elements, such as:

- A compliance system (discipline, re-training, etc.).
- A communication system (to and from employees).
- Procedures for conducting periodic safety inspections.
- Procedures for investigating injuries or illnesses.
- Procedures for correcting unsafe conditions.
- Training and instruction.

Every on-site inspection that Cal/OSHA conducts must include an evaluation of the employer's IIPP, which entails:

- Ensuring that the employer's IIPP contains required elements.
- Interviewing a sample of employees.
- Considering the effectiveness of the IIPP's implementation in practice.

Example: Does implementation of the employer's safety inspection procedures result in a comprehensive evaluation of the hazards present at the workplace?

Case Example #1 – Accident (fatality)

- Documented and evaluated the employer's written IIPP using a basic checklist.
- Interviewed workers and management about the IIPP's effectiveness.
- Explained in the case file how the IIPP had been ineffective in practice.

RESULT: Cited the employer for IIPP-related violations and documented changes the employer made to improve its safety program.

Case Example #2 – Complaint

- Documented and evaluated the employer's written IIPP using a basic checklist.
- Did not document any interviews about the IIPP's effectiveness.
- Did not evaluate in the case file the IIPP's implementation in practice.

RESULT: Did not cite the employer for any IIPP-related violations, and it was unclear whether any were warranted.

Case Example #3 – Accident (fatality)

- Documented the employer's written IIPP but did not evaluate it using a basic checklist.
- Documented brief notes from only two interviews, and the notes contained information that was only indirectly related to the IIPP's effectiveness.
- Did not evaluate in the case file the IIPP's implementation in practice.

RESULT: Did not cite the employer for any IIPP-related violations, even though there were indications that violations may have existed.

Source: State law, Cal/OSHA policies and procedures, and complaint and accident case files.

We found similar issues in multiple accident inspections we reviewed, which was particularly concerning because it was unclear whether deficient employer safety programs may have contributed to workers' deaths and injuries. For example, in one fatal accident we describe in Figure 9, the case file included the employer's written IIPP but did not contain any documentation that the inspector had evaluated it or its implementation, and Cal/OSHA did not issue any citations related to the IIPP. However, there were indications in the case file that an IIPP violation may have occurred. For instance, the inspector's interview notes mentioned that it was "common practice" for employees to operate equipment in an unsafe manner. Further, Cal/OSHA cited the same employer for an IIPP-related violation after inspecting another fatal accident at a different worksite just a few months later.

Some district managers told us that inspectors are familiar with IIPP requirements and analyze the effectiveness of the IIPP even if they may not document this analysis in the case file. One manager indicated that checklists or similar forms do not capture the complexity of an effective IIPP analysis and can be a paperwork burden for inspectors. Cal/OSHA policy contains detailed guidelines for these IIPP analyses but does not specify how to document them. Without some level of documentation, Cal/OSHA cannot demonstrate that inspectors are conducting reviews of the IIPP as required, which increases the risk that they may overlook IIPP violations that put workers in harm's way.

Similarly, Cal/OSHA may not have interviewed enough workers in about half our selected complaint inspections and did not always interview witnesses or workers most familiar with the alleged violations. Cal/OSHA inspectors use witness statements as evidence to document the existence of a violation. State law and Cal/OSHA's procedures require inspectors to interview a "sample" of employees—which Cal/OSHA policy further specifies must include supervisors—as part of any evaluation of an employer's IIPP. However, neither state law nor Cal/OSHA policy provides a number or percentage of employees that would constitute a representative sample. In three of our 15 selected complaint inspections, inspectors conducted only a single interview; in two of these cases, the sole interviewee was a manager. Without interviews from a variety of sources, Cal/OSHA may miss crucial perspectives and sources of evidence.

Further, when Cal/OSHA did conduct interviews, it did not always correctly document them, weakening the interviews' reliability as evidence. Cal/OSHA's inspection policies direct inspectors to try to record audio of all interviews or to obtain signed, written statements from interviewees whenever possible. If interviewees refuse to allow audio recording or to provide a written statement, inspectors must thoroughly and legibly document all statements on a note-taking sheet. In addition, when interviewing non-English-speaking workers, inspectors must use appropriate language translators—either DIR-certified bilingual employees or individuals available through a contracted language translation vendor. However, Cal/OSHA did not ensure that inspectors followed all these policies when conducting and documenting interviews. For example, five complaint inspection case files contained interview notes that were difficult to read, overly brief, undated, or unclear as to which individual made each statement. Five of the complaint inspections also likely included interviews conducted in a language other

than English, but none of these five case files included clear documentation that the interviews involved an appropriate translator. When we spoke with Cal/OSHA's chief and deputy chief about these issues, they told us that many workers are not comfortable being recorded but acknowledged that Cal/OSHA could change its interview training and guidance to emphasize the importance of recording interviews when possible. The chief and deputy chief added that when Cal/OSHA transitions to using an electronic case management system, that system will help ensure that interview notes are legible and easily accessible.

Issues with Cal/OSHA's documentation of interviews and other evidence were sometimes made worse because inspectors did not clearly explain how the evidence they had collected supported a violation. Cal/OSHA policy requires inspectors to determine during an on-site inspection whether the employer violated each required element of a regulation and to complete violation worksheets that help identify and organize the evidence proving the violation. Doing so can help ensure that Cal/OSHA issues citations that are fair and will withstand an employer's appeal. However, these worksheets were not always complete, reducing assurances that Cal/OSHA could support the violations with appropriate evidence. In three complaint cases we reviewed, inspectors used different versions of the worksheet that required fewer details and did not include fields to explain the supporting evidence. One case file was missing three of the worksheet's five pages, omitting most elements of the violated regulation and the description of the supporting evidence. In one of the fatal accidents we reviewed, the case file did not contain any violation worksheets at all. After the employer appealed, Cal/OSHA reduced the only violation it had found from a serious accident-related violation to a general violation with a $600 fine.

Broader underlying problems with Cal/OSHA's processes and staffing levels, which we discuss in more detail later in the report, likely contributed to the inspection deficiencies we identified. For example, some district managers told us that understaffing contributed to incomplete case files and that they had limited time to review inspectors' work because of high caseloads. A 2023 internal audit found that Cal/OSHA's inspection case files were not always complete. This finding cited some files that were missing documentation related to interview notes and violation worksheets, and it indicated that outdated policies and multiple versions of some forms were part of the problem. The internal audit also noted that only nine of 17 district managers had taken formal training on case management and review.

Cal/OSHA Did Not Initiate Some Inspections in a Timely Manner, and the Appeal Process Often Significantly Delayed Case Closures

Cal/OSHA did not start all its complaint inspections in a timely manner, which can subject workers to ongoing risks and make it more difficult for Cal/OSHA to identify workplace violations and collect evidence. When Cal/OSHA receives a complaint of an unsafe workplace from an employee or an employee's representative, state law requires the division to investigate within three working days for complaints alleging serious violations and within 14 calendar days for those alleging non-serious violations.

Cal/OSHA Missed Deadlines to Inspect Four of Our 15 Selected Complaints

Case #1: Failure to Report Amputated Finger

Complaint Received: 7/19/22*

Inspection Due: 8/2/22

Site Inspected: 8/24/22 (~3 weeks late)

Case #2: Lack of Fall Protection (& Others)

Complaint Received: 2/5/24†

Inspection Due: 2/19/24

Site Inspected: 2/23/24 (~1 week late)

Case #3: Failure to Report Injury From Fall

Complaint Received: 12/5/22

Inspection Due: 12/8/22

Site Inspected: 2/6/23 (~2 months late)

Case #4: Exposure to Hazardous Chemicals

Complaint Received: 5/10/22

Inspection Due: 5/13/22

Site Inspected: 6/27/22 (~1.5 months late)

Source: Labor Code section 6309 and Cal/OSHA case files.

* Complaint alleged that the complainant had previously notified Cal/OSHA of the accident on 4/8/22.

† Cal/OSHA grouped this complaint with other related complaints, including some it received in early January 2024.

Cal/OSHA policy further requires investigation of imminent hazard complaints within 24 hours.[3] As the text box shows, Cal/OSHA initiated four of our 15 selected complaint inspections after the deadlines in state law. More broadly, the rate at which Cal/OSHA started inspections after these deadlines varied by the severity of the complaint. As we show in Appendix A, Table A.9, for valid complaints it inspected in fiscal year 2023–24, Cal/OSHA initiated inspections of 9 percent of imminent hazard complaints after two days, 25 percent of serious complaints after six days, and 41 percent of other complaints after 15 days.

We had more difficulty assessing Cal/OSHA's timeliness in initiating inspections of certain complaints because neither state law nor Cal/OSHA policy has clear deadlines in place. The deadlines in Labor Code section 6309 apply to several types of complaints but do not apply to complaints that Cal/OSHA receives from former employees, anonymous sources who may not be employees, or uninvolved third parties such as bystanders who may observe a hazard. Cal/OSHA generally refers to these types of complaints as *non-formal* and investigates them by letter, but its policy requires on-site inspections under certain circumstances—for example, if the complaint alleges an imminent hazard—and allows personnel to use their discretion to conduct inspections in others. Although Cal/OSHA policy states that imminent hazards must be inspected on-site within 24 hours, for most other types of non-formal complaints, Cal/OSHA's policies do not provide guidance on how soon personnel should begin an inspection. For example, in one of our selected cases, a neighbor to a construction site reported to Cal/OSHA that workers did not have fall protection and that the employer was not using adequate traffic controls to protect workers in the street. Cal/OSHA staff categorized the complaint as a *serious* hazard—not an *imminent* hazard—but assigned it for on-site inspection anyway. However, Cal/OSHA did not conduct the inspection for four months.

Similarly, Cal/OSHA lacks clear deadlines for initiating on-site inspections of non-fatal accidents, and three cases we reviewed involved delayed inspections. State law requires Cal/OSHA to prioritize investigations of accidents involving fatalities or serious

[3] A *serious violation* means that there is a realistic possibility that death or serious physical harm could result from the alleged hazard. All other complaints are deemed to allege *non-serious violations*. Cal/OSHA policy further defines *imminent hazard* complaints as those alleging a hazard that could reasonably be expected to cause death or serious physical harm immediately or before the hazard can be eliminated through regular enforcement procedures.

injuries or illnesses before investigations of complaints that allege non-serious hazards, but it does not establish any specific deadlines for investigating accidents, apart from the six-month deadline for issuing citations that applies to any type of inspection. Cal/OSHA policy directs personnel to initiate on-site inspections of fatal accidents within 24 hours, and in all three fatal accidents we reviewed, Cal/OSHA began its inspection within 24 hours. For non-fatal accidents, however, Cal/OSHA policy merely directs personnel to initiate an inspection "within a reasonable time." We selected five non-fatal accident inspections for review, and Cal/OSHA initiated three of these inspections one month or more after the accident occurred. According to federal enforcement procedures, injury inspections should begin within five working days, resources permitting. A 2023 federal monitoring report found that in fiscal year 2022–23, Cal/OSHA took an average of 16.5 working days to begin a non-fatal accident inspection.

District managers generally attributed delays in initiating inspections to staffing shortages and noted that they had to prioritize inspecting more serious accidents or more dangerous hazards. Cal/OSHA staff must continually reprioritize their work to meet the demands of incoming complaints and accidents, and it is reasonable to prioritize the most important on-site inspections and ensure that these inspections are effective and thorough.

Nevertheless, delays in starting inspections can have real consequences and put workers at risk. In industries such as agriculture and construction, the conditions and employees at a given worksite can change from day to day, and starting an inspection late means that Cal/OSHA may face additional difficulty proving the existence of a violation. For example, in the complaint we describe that had a four-month delay, by the time the on-site inspection began, the employer had already completed construction, and Cal/OSHA was only able to issue a citation for a minor permit-related violation. For inspections of accidents, delays can hinder Cal/OSHA's ability to collect and analyze evidence, including physical evidence such as machinery or equipment, documentary evidence such as photos or videos of the accident site, and witness statements.

Another reason that Cal/OSHA's cases can take months or even years to resolve is the appeals process that begins after Cal/OSHA issues its citations. For example, one-quarter of complaints that Cal/OSHA inspected during our audit period took 170 days or longer from when Cal/OSHA completed its inspection until it was able to close the case. If the employer appeals Cal/OSHA's citations, the case then enters a process largely overseen by the appeals board—a judicial body within DIR that is independent from Cal/OSHA—during which Cal/OSHA and the employer can choose to negotiate a settlement agreement that finalizes the case. In our selection of complaints and accidents, employers appealed in 15 of the 18 cases that included citations, and 10 of those appealed cases took more than a year from the initial complaint or accident to the final settlement agreement or order. This lengthy process can have numerous effects, including delaying closure for workers or family members and costing Cal/OSHA time and resources. Although enforcement personnel do not have control over important aspects of the appeals process, such as the appeals board's workload or the availability of administrative law judges, Cal/OSHA could ensure that it thoroughly supports its citations with evidence that could help discourage unnecessary appeals.

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Cal/OSHA Could Better Ensure That Employers Maintain Safe Workplaces

Key Points

- Five of the 11 complaint inspections we reviewed that contained citations lacked evidence that employers abated all hazards that Cal/OSHA had identified. In addition, evidence in the accident case files we reviewed did not always demonstrate that employers' abatement had sufficiently addressed the causes of the accidents.

- Cal/OSHA's initial fine determinations for some complaint and accident inspections were less severe than regulations and policy may have warranted, such as one worker fatality in which Cal/OSHA assessed just $21,000 in fines when we determined that it may have been able to assess almost double that amount. Cal/OSHA also often did not document a clear rationale for its decisions to reduce fines in post-citation negotiations with employers, such as by explaining why reductions were reasonable given the employer's assertions.

- Of the three fatal accidents we reviewed, Cal/OSHA's bureau of investigations referred only one to a prosecuting authority for potential criminal prosecution, and its files did not contain detailed reasoning explaining these decisions to refer or not to refer the cases to prosecutors. Further, the bureau could not provide us with documentation that it had reviewed inspection reports for four non-fatal accidents in our selection. These non-fatal accidents included workers suffering serious injuries such as amputations.

Cal/OSHA Did Not Always Require Employers to Prove That They Fully Abated Violations

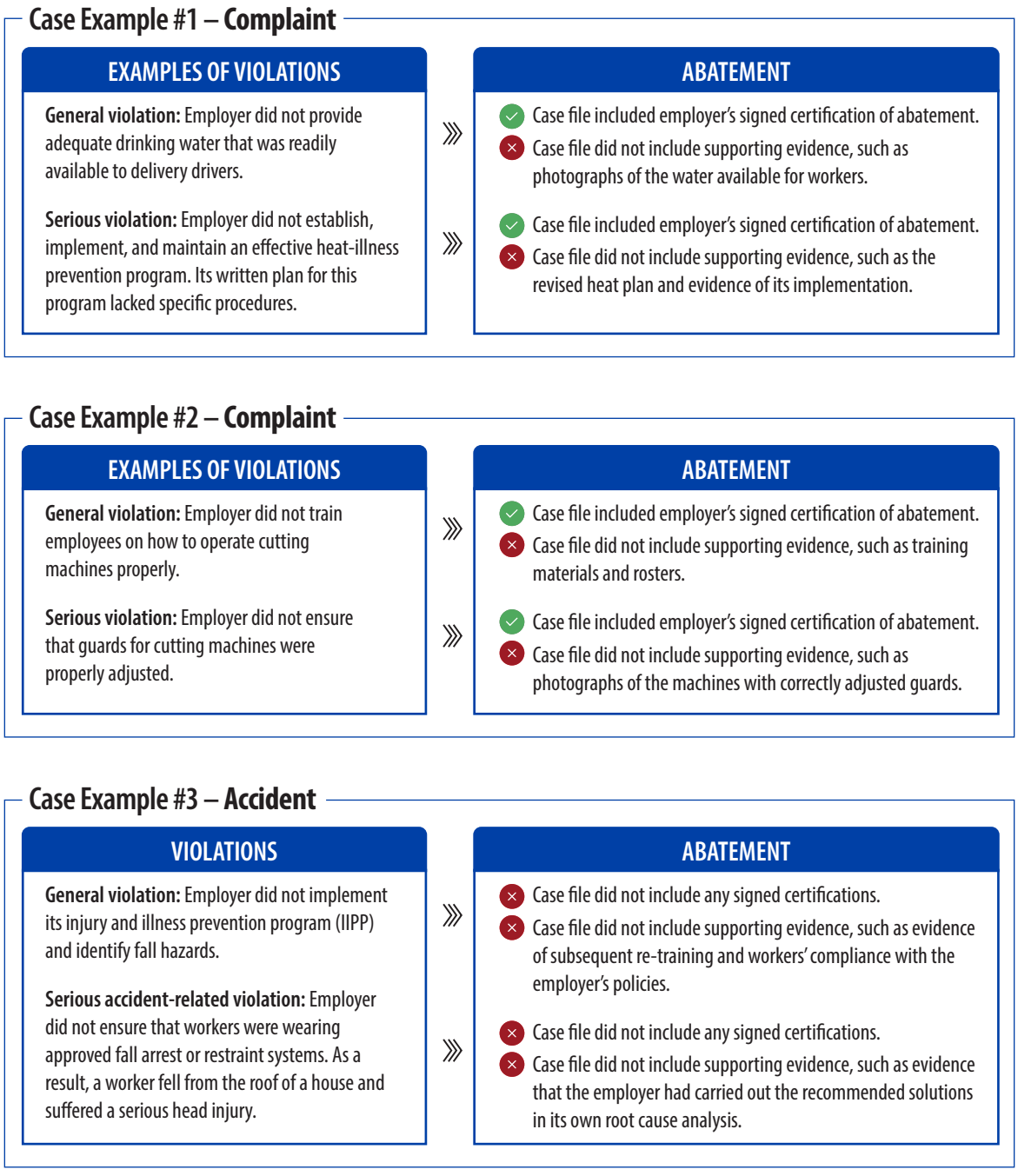
Abatement is the process by which employers correct hazards that Cal/OSHA has identified during an inspection. Without evidence of abatement, Cal/OSHA risks leaving workers exposed to ongoing hazards. There are two types of evidence that case files may include to demonstrate employers' abatement: the employer's signed certification that they have abated the hazard—although this is not required if Cal/OSHA personnel note in the citation that they observed abatement themselves—and supporting evidence verifying the certification, such as photographs or evidence of the purchase or repair of equipment. Although state law and Cal/OSHA policy generally require signed certifications of abatement, they offer less-comprehensive requirements for supporting evidence. For example, regulations require the employer to provide supporting evidence of abatement for each *willful* or *repeat* violation but do not require the supporting evidence for *serious* violations unless Cal/OSHA decides it is necessary. Cal/OSHA policy does not specify how enforcement personnel should decide whether supporting evidence is necessary for serious violations and does not require supporting evidence for general violations.

The case files we reviewed often lacked evidence that employers had abated violations. Five of the 11 complaint inspections we reviewed that contained citations lacked either certifications or supporting evidence to indicate that employers had corrected all hazards that Cal/OSHA had identified. Figure 10 illustrates examples of our concerns. Similar to our findings, federal OSHA found in 2023 that 27 percent of Cal/OSHA's files lacked sufficient documentation of abatement. It also found that in 39 percent of cases in which employers had reportedly corrected violations during the inspection, there was no documentation that Cal/OSHA inspectors had observed or verified the abatement. Cal/OSHA managers told us that ensuring adequate abatement, such as by requesting and evaluating detailed evidence, is challenging because of Cal/OSHA's time and resource constraints. Cal/OSHA's deputy chief of enforcement also told us that Cal/OSHA cannot require prescriptive abatement; rather, the employer must explain how they abated each violation, and Cal/OSHA personnel then determine whether the abatement is sufficient. One district manager indicated that the amount and type of evidence that is "sufficient" to prove abatement depends on the violation. Another district manager stated that the employer largely determines the long-term success or failure of abatement. Even so, abatement is the process by which Cal/OSHA can gain assurance that its inspections have resulted in positive change that better protects workers. It is therefore worth spending time to evaluate and document abatement thoroughly.

In addition to the documentation concerns we depict in Figure 10, it was not always clear that employers' abatement had sufficiently addressed the causes of the accidents we reviewed. State law authorizes, and in some cases requires, Cal/OSHA to investigate workplace accidents, including investigating their causes and issuing any orders necessary to eliminate those causes. Further, according to Cal/OSHA's accident inspection procedures, the primary purpose of an accident inspection is to determine the accident's cause, and every inspection should include a comprehensive evaluation of the accident's circumstances and causes.

However, in several accidents we reviewed, Cal/OSHA did not clearly explain in the case file all potential causes that its inspection had uncovered and link them with the employer's abatement actions to demonstrate that those actions were sufficient. For example, in two fatality cases, evidence in the case file suggested that factors associated with the layouts of the employers' worksites may have contributed to the workers' deaths. For instance, in one case, there was a sloped surface that may have contributed to a stack of materials tilting, falling, and crushing a worker. Nevertheless, neither case file included evidence that the employers had taken abatement actions related to these specific factors, and in one of the two cases, the case file did not even document whether Cal/OSHA considered the worksite's layout to be a causal factor in the accident. Two other accidents that involved serious injuries occurred at temporary worksites, such as a site at which workers were trimming trees, and both case files listed the abatement as "corrected during inspection" without providing any signed certifications or explanations from Cal/OSHA about what it considered to be effective abatement. One reason that those files lacked abatement information may have been that for temporary worksites, Cal/OSHA policy considers a violation abated when work is completed at the inspected worksite or when the violative structure or physical condition no longer exists.

Figure 10
Cal/OSHA Did Not Always Ensure That Employers Abated Workplace Hazards


Case Example #1 – Complaint
EXAMPLES OF VIOLATIONS
General violation: Employer did not provide adequate drinking water that was readily available to delivery drivers.
Serious violation: Employer did not establish, implement, and maintain an effective heat-illness prevention program. Its written plan for this program lacked specific procedures.
ABATEMENT
Case file included employer's signed certification of abatement.
Case file did not include supporting evidence, such as photographs of the water available for workers.
Case file included employer's signed certification of abatement.
Case file did not include supporting evidence, such as the revised heat plan and evidence of its implementation.
Case Example #2 – Complaint
EXAMPLES OF VIOLATIONS
General violation: Employer did not train employees on how to operate cutting machines properly.
Serious violation: Employer did not ensure that guards for cutting machines were properly adjusted.
ABATEMENT
Case file included employer's signed certification of abatement.
Case file did not include supporting evidence, such as training materials and rosters.
Case file included employer's signed certification of abatement.
Case file did not include supporting evidence, such as photographs of the machines with correctly adjusted guards.
Case Example #3 – Accident
VIOLATIONS
General violation: Employer did not implement its injury and illness prevention program (IIPP) and identify fall hazards.
Serious accident-related violation: Employer did not ensure that workers were wearing approved fall arrest or restraint systems. As a result, a worker fell from the roof of a house and suffered a serious head injury.
ABATEMENT
Case file did not include any signed certifications.
Case file did not include supporting evidence, such as evidence of subsequent re-training and workers' compliance with the employer's policies.
Case file did not include any signed certifications.
Case file did not include supporting evidence, such as evidence that the employer had carried out the recommended solutions in its own root cause analysis.

Source: Complaint and accident case files.

When we spoke with Cal/OSHA leadership about accident causes and abatement, they stated that Cal/OSHA lacks jurisdiction over some causes of accidents, such as corporate culture, and has no mandate or authority to make recommendations about things outside of the Labor Code and Title 8 regulations. They also pointed out that Cal/OSHA has a limited amount of time to investigate the causes of accidents, especially compared to certain federal agencies that investigate specific types of workplace accidents and may take years to release lengthy reports. Nevertheless, it is reasonable to expect Cal/OSHA personnel to explicitly and comprehensively document the potential causes or contributing factors that they uncover during the normal course of their accident inspections, such as by conducting effective interviews and analyzing the evidence they have collected. Further, when these causes or factors are reasonably related to a workplace violation, Cal/OSHA should ensure that the employer's abatement efforts address the accident causes or contributing factors.

Compounding the consequences of these abatement issues, Cal/OSHA has rarely conducted follow-up inspections to confirm that employers have abated all cited violations. In many circumstances, conducting a follow-up inspection is discretionary, but state law requires Cal/OSHA to reinspect at least 20 percent of randomly selected inspections with serious violations that were not abated during the inspection—of which there were likely hundreds during our audit period. However, from fiscal years 2019–20 through 2023–24, Cal/OSHA's data indicate that it conducted a total of only 16 follow-up inspections, which likely falls significantly short of the 20 percent requirement. None of these follow-up inspections were related to accident or complaint cases. District managers told us that they do not have enough staff available to assign follow-up inspections and that they must prioritize conducting new inspections of incoming complaints and accidents.

Cal/OSHA Often Lacked Documented Justification for Its Decisions to Reduce Fine Amounts

When Cal/OSHA identifies through on-site inspections that employers have violated workplace regulations, it issues citations and assesses fines. Fines may help protect workers by deterring employers from committing violations, but the effectiveness of fines can vary. For example, we spoke with Cal/OSHA district managers who felt that fines were generally effective in incentivizing employers' compliance with regulations but that fine effectiveness varied by the size of the employer. Indeed, some of the businesses that Cal/OSHA fined dozens of times during our audit period likely have enough revenue that the fine amounts are not a significant deterrent. Changes to the way regulations direct Cal/OSHA to calculate fines—such as to increase fines more drastically for large employers or when a serious injury or fatality occurs—could be reasonable. However, Cal/OSHA should begin by better justifying its use of the existing fine parameters to ensure that it assesses appropriately high fines.

The specific parameters that California has established for fining employers generally include higher fines than in some other states. State law and regulations outline these parameters, and Cal/OSHA then makes decisions about how to apply the parameters relative to the specific circumstances of each inspection. As the text box shows, California also has a higher base fine amount for serious violations than the amounts in federal guidelines. In fact, federal OSHA found that in 2023, Cal/OSHA's average fine for serious violations was $8,800, compared to the three-year national average of $3,600.

California's Parameters for Serious Violation Fines Are Higher Than Federal Parameters

- Serious Violation
  - California: $18,000 +/- 50% (maximum of $25,000)
  - Federal: $7,093–$16,550
- Examples of Available Reductions
  - California
    - i. History: up to 10%
    - ii. Size: up to 40%
  - Federal
    - iii. History: +/- 10%
    - iv. Size: up to 70%

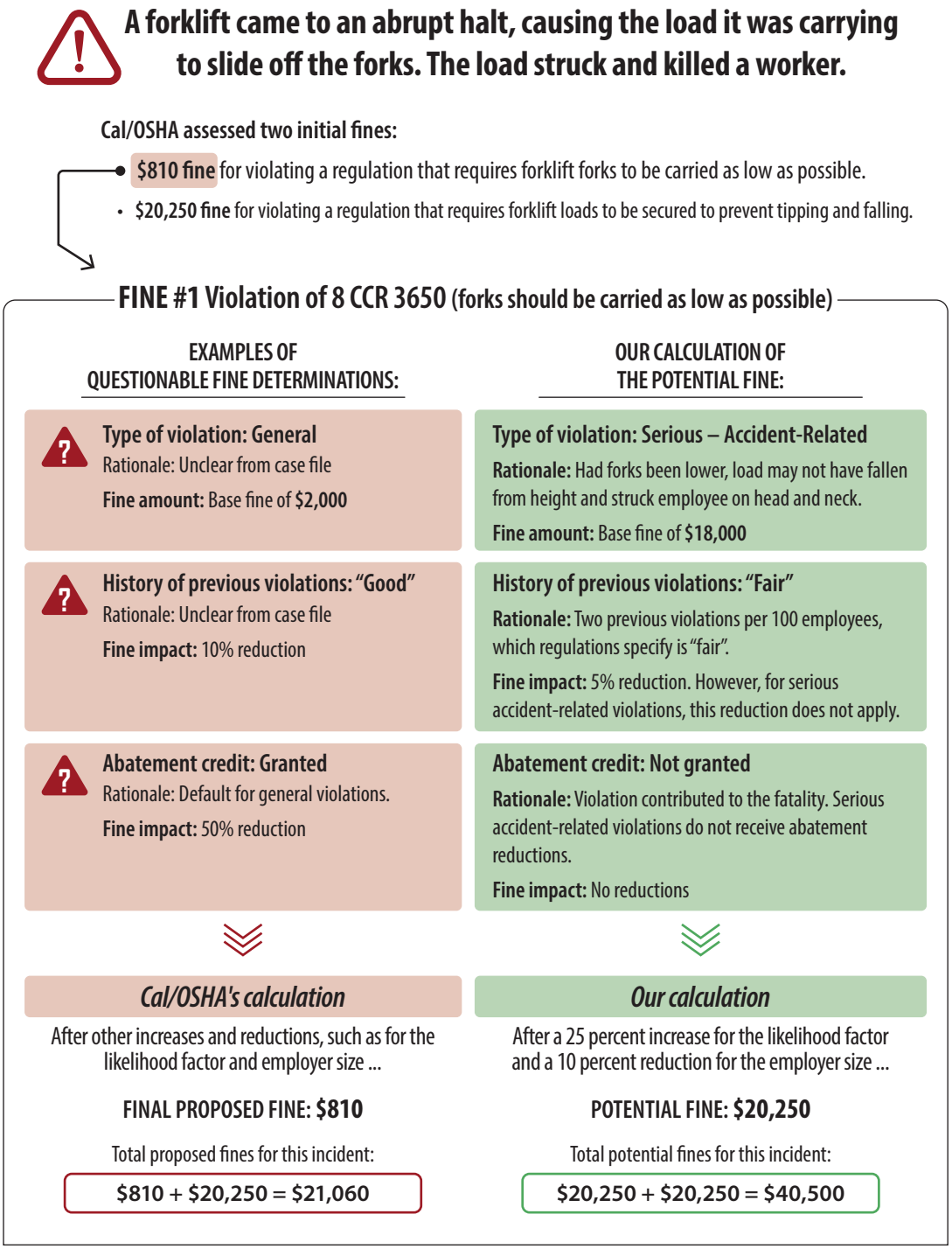
Source: Title 8 sections 333 through 336 and federal OSHA Field Operations Manual.

Nevertheless, on an inspection-by-inspection basis, Cal/OSHA has issued lower fine amounts than other states have. Federal OSHA found that in 2023, Cal/OSHA's average fine per inspection was just $5,900 when the national average was $8,900. Federal OSHA attributed this discrepancy to the low number of serious violations that Cal/OSHA issued per inspection: Federal OSHA calculated this number to be 0.67 serious, willful, and repeat violations per inspection, compared to the three-year national average of 1.75. Although employers and regulations vary by state, and factors beyond the quality of Cal/OSHA's inspections could contribute to this difference, Cal/OSHA leadership acknowledged that the low rate of serious violations per inspection is concerning and told us that DIR will conduct an internal audit to examine potential causes of the low rate. Further, we found examples in the case files we reviewed that suggest Cal/OSHA could have imposed more severe violations and fines.

Cal/OSHA's Initial Fine Determinations Were Less Severe Than Some Complaint and Accident Inspections May Have Warranted

We reviewed Cal/OSHA's fine determinations for 20 violations across 10 judgmentally selected complaint and accident inspections. In the 10 cases we reviewed, we identified two instances in which Cal/OSHA classified a violation as *general*, but the underlying facts of the violation—and Cal/OSHA's lack of documented rationale for its decision—led us to question whether the classification should have been *serious*. Figure 11 describes one of these cases and how the general violation classification reduced the initial fine amount. The district manager, who said that he did not work directly on that case, speculated that the reason for the general classification may have been that a serious violation required evidence of employer knowledge of the hazard. However, this rationale was not documented in the case file. Further, Cal/OSHA policy states that a supervisor's knowledge of a hazard constitutes employer knowledge—and in this case, it was a supervisor who was operating the forklift involved in the accident.

Figure 11
Questionable Determinations May Have Led Cal/OSHA to Impose About Half the Fine Amount It Could Have for One Fatality Case


A forklift came to an abrupt halt, causing the load it was carrying to slide off the forks. The load struck and killed a worker.
Cal/OSHA assessed two initial fines:
$810 fine for violating a regulation that requires forklift forks to be carried as low as possible.
$20,250 fine for violating a regulation that requires forklift loads to be secured to prevent tipping and falling.
FINE #1 Violation of 8 CCR 3650 (forks should be carried as low as possible)
EXAMPLES OF QUESTIONABLE FINE DETERMINATIONS:
OUR CALCULATION OF THE POTENTIAL FINE:
Type of violation: General
Rationale: Unclear from case file
Fine amount: Base fine of $2,000
Type of violation: Serious – Accident-Related
Rationale: Had forks been lower, load may not have fallen from height and struck employee on head and neck.
Fine amount: Base fine of $18,000
History of previous violations: "Good"
Rationale: Unclear from case file
Fine impact: 10% reduction
History of previous violations: "Fair"
Rationale: Two previous violations per 100 employees, which regulations specify is "fair".
Fine impact: 5% reduction. However, for serious accident-related violations, this reduction does not apply.
Abatement credit: Granted
Rationale: Default for general violations.
Fine impact: 50% reduction
Abatement credit: Not granted
Rationale: Violation contributed to the fatality. Serious accident-related violations do not receive abatement reductions.
Fine impact: No reductions
Cal/OSHA's calculation
After other increases and reductions, such as for the likelihood factor and employer size ...
FINAL PROPOSED FINE: $810
Total proposed fines for this incident:
$810 + $20,250 = $21,060
Our calculation
After a 25 percent increase for the likelihood factor and a 10 percent reduction for the employer size ...
POTENTIAL FINE: $20,250
Total potential fines for this incident:
$20,250 + $20,250 = $40,500

Source: Case file and Title 8 regulations.

Cal/OSHA also often did not document its reasoning for how it determined more specific fine adjustment factors, some of which we show in Figure 11. In 14 of the 20 violations we reviewed, Cal/OSHA did not document adequate justification for at least one fine adjustment factor, and the specifics of the case caused us to question the appropriateness of the resulting fine amount. In 11 of these 14 cases, the questionable fine adjustment factors caused the fine to be lower than the violation may have warranted. For example, one of the adjustment factors that Cal/OSHA must assess is the likelihood that injury or illness will occur as a result of the violative condition. This likelihood factor can reduce the base fine amount by 25 percent if Cal/OSHA rates it as *low*. The likelihood factor results in no change to the fine if Cal/OSHA rates it as *medium*, and it increases the fine by 25 percent if Cal/OSHA rates it as *high*. However, case files we reviewed sometimes included low or medium ratings—including for violations that contributed to workers suffering amputations—and provided no justification or further explanation of how the inspector had reached that conclusion.

Although regulations include definitions for the classification and adjustment factors of each fine, and Cal/OSHA policies require personnel to thoroughly and correctly document these components, the policies rarely specify where personnel should justify their determinations in the case file. For example, Cal/OSHA policy states that if a serious violation caused a death or serious injury, personnel must characterize the violation as *accident-related*, which can result in higher fines. However, the policy does not specify where or how personnel should explain their reasoning about whether a violation caused an accident. This vagueness in policy is especially problematic because we encountered different interpretations of *accident-related*. For example, one district manager told us it meant that a causal relationship or nexus must exist between the injury and the violation, and another manager told us it meant a direct relationship must exist, meaning that an accident could not have occurred without the violation. We observed two specific forms in case files that were generally relevant to fine determinations—a fine calculation worksheet and a violation worksheet—but personnel often used these forms merely to state their determinations rather than to explain their rationales or the evidence supporting those determinations.

Cal/OSHA Often Did Not Adequately Explain Its Decisions to Reduce Fines in Post-Citation Negotiations With Employers

After Cal/OSHA determines the initial fine amounts and issues citations to employers, Cal/OSHA can reduce those initial fines for different reasons, including through negotiations with the employers. As we note in the Introduction, the appeals board, which is independent from Cal/OSHA, also has a role in this process: for instance, it approves the settlement agreements that Cal/OSHA negotiates with employers after the employers have appealed. According to Cal/OSHA's chief counsel, the appeals board routinely schedules settlement conferences between Cal/OSHA and employers in appealed cases and requires the parties to come prepared with stipulations and settlement authority. The chief counsel stated that during these conferences, the administrative law judge's role is to identify strengths and weaknesses and encourage compromise and resolution. We found that from

fiscal years 2019–20 through 2023–24, of the 23,195 inspections that included initial fines, 8,362, or 36 percent, had subsequent fine reductions. Although fine reductions varied in size, we found the average reduction for individual fines to be $2,041, or 56 percent, and the highest fine reduction was $371,000.

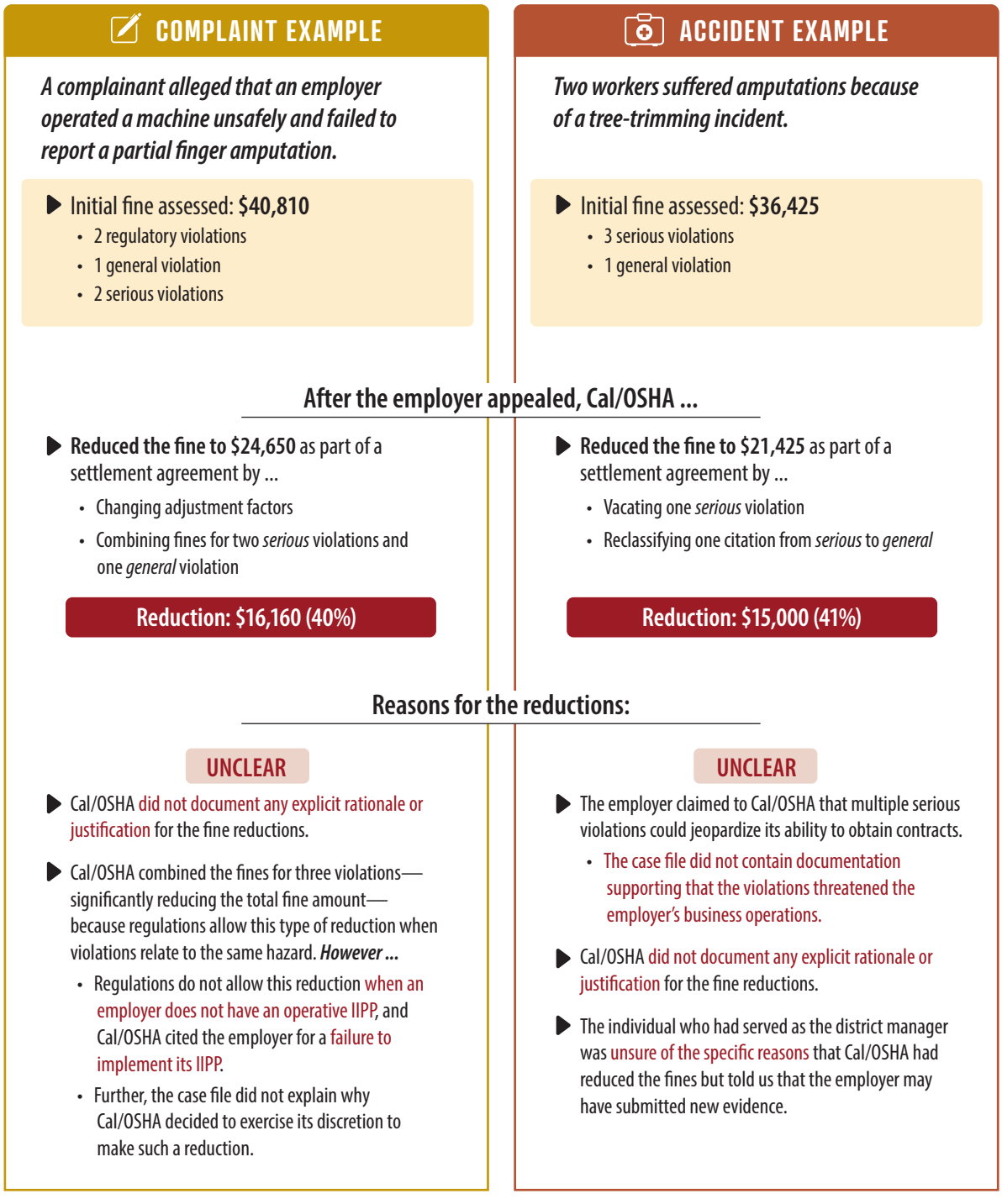
Cal/OSHA policies generally require personnel to document the reasons for post-citation changes to fine amounts, but these policies are not always clear or comprehensive. For example, Cal/OSHA policy specifies that the district manager or designee shall document post-citation conferences with the employer on a particular form, and that the documentation include the reasons for any changes made to citations or fines. However, the form does not contain a specific location for Cal/OSHA's rationale for making these changes, and the policy does not make clear how to document rationales when Cal/OSHA makes changes outside of conferences, such as when it makes changes after reviewing evidence in the case or exchanging subsequent emails with the employer. Cal/OSHA's policies are also unclear about who is responsible for documenting rationales for fine reductions when Cal/OSHA attorneys are involved in the decision, nor do the policies specify where personnel should maintain documentation that may be attorney-client privileged.

In the absence of comprehensive guidelines, six of the eight cases we reviewed that included more than $10,000 in fine reductions did not contain a clear rationale—either in the case file or, when relevant, in additional documents that Cal/OSHA's legal unit had maintained—for why the reductions were warranted. Figure 12 includes examples of two such cases that raised concerns for us about the reasonableness of the fine reductions. However, not all fine reductions that lacked this type of documentation were necessarily unreasonable. For example, when we spoke with an inspector who had worked on another of the accident cases we reviewed, the inspector explained that in exchange for a large fine reduction, Cal/OSHA was able to keep a willful violation in place and avoid the risks and time associated with proceeding to a hearing on the case. Further, the inspector provided us with documentation showing that division attorneys and enforcement unit leadership had been aware of and pleased with the case's settlement at the time.

Another reason that Cal/OSHA may reclassify violations and reduce fines is because of weaknesses in its evidence. For example, in one complaint inspection related to the provision of drinking water for farm workers, Cal/OSHA documented a case summary with specific details that helped explain why it had agreed in a settlement to reduce a repeat serious violation to a repeat general violation and change the total fine amount from nearly $20,000 to less than $3,000. Performing more thorough inspections and explaining the evidence that supports each violation could help Cal/OSHA avoid these types of fine reductions in the first place. But when such fine reductions do occur, it is important to explain the reasons for them—whether in the legal unit's files or in the main case file—as Cal/OSHA did in that instance.

Documenting the specific reasons for why fine reductions are warranted is particularly necessary given that in 2018, a district manager at Cal/OSHA was convicted on charges of receiving a bribe from a company in exchange for reducing fines for workplace safety violations. Consistently documenting a clear rationale for fine reductions is essential for maintaining transparency and accountability.

Figure 12
Cal/OSHA Did Not Always Document Rationales or Evidence Supporting Its Reductions of Employers' Fines


COMPLAINT EXAMPLE
A complainant alleged that an employer operated a machine unsafely and failed to report a partial finger amputation.
Initial fine assessed: $40,810
2 regulatory violations
1 general violation
2 serious violations
ACCIDENT EXAMPLE
Two workers suffered amputations because of a tree-trimming incident.
Initial fine assessed: $36,425
3 serious violations
1 general violation
After the employer appealed, Cal/OSHA ...
Reduced the fine to $24,650 as part of a settlement agreement by ...
Changing adjustment factors
Combining fines for two serious violations and one general violation
Reduction: $16,160 (40%)
Reduced the fine to $21,425 as part of a settlement agreement by ...
Vacating one serious violation
Reclassifying one citation from serious to general
Reduction: $15,000 (41%)
Reasons for the reductions:
UNCLEAR
Cal/OSHA did not document any explicit rationale or justification for the fine reductions.
Cal/OSHA combined the fines for three violations—significantly reducing the total fine amount—because regulations allow this type of reduction when violations relate to the same hazard. However ...
Regulations do not allow this reduction when an employer does not have an operative IIPP, and Cal/OSHA cited the employer for a failure to implement its IIPP.
Further, the case file did not explain why Cal/OSHA decided to exercise its discretion to make such a reduction.
UNCLEAR
The employer claimed to Cal/OSHA that multiple serious violations could jeopardize its ability to obtain contracts.
The case file did not contain documentation supporting that the violations threatened the employer's business operations.
Cal/OSHA did not document any explicit rationale or justification for the fine reductions.
The individual who had served as the district manager was unsure of the specific reasons that Cal/OSHA had reduced the fines but told us that the employer may have submitted new evidence.

Source: Complaint and accident case files, and state law.

Cal/OSHA's Bureau of Investigations Has Lacked the Policies and Staffing Necessary to Ensure That It Consistently Refers Cases for Potential Criminal Prosecution

State Law Requires the Bureau of Investigations to Investigate Certain Accidents and to Consider Investigating Others

The bureau **must investigate** accidents when:

- They involve workplace violations, and ...
  - A fatality has occurred.
  - A serious injury to five or more workers has occurred.
  - A Cal/OSHA representative requests prosecution.

The bureau **must review inspection reports** of accidents when:

- The accident involves a serious violation, and ...
  - A serious injury to one to four employees or a serious exposure has occurred.
    - » The bureau **may investigate** those cases in which it finds that criminal violations may have occurred.

Source: Labor Code section 6315.

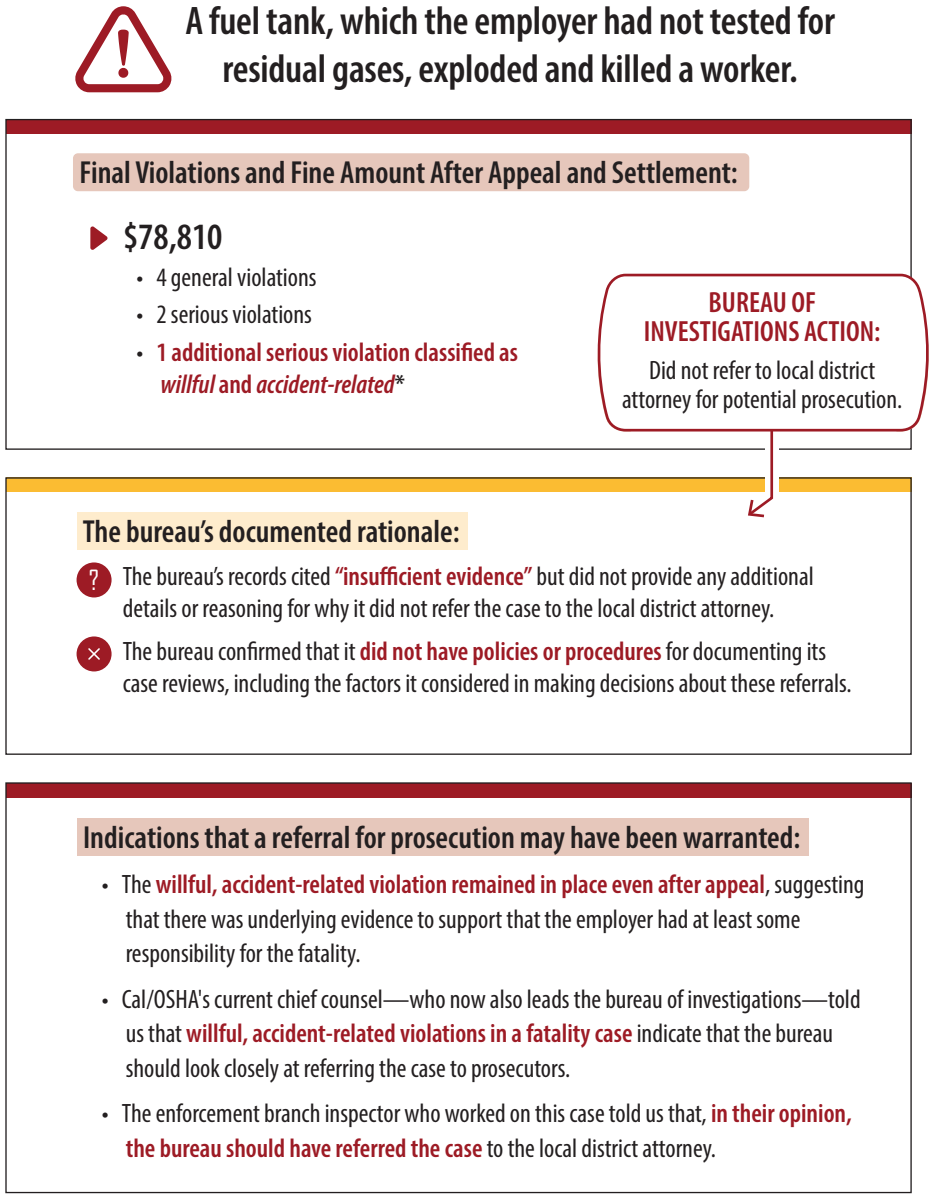
As we discuss in the Introduction, the bureau of investigations is a unit within Cal/OSHA responsible for preparing accident cases for potential criminal prosecution, and its work is separate from the inspections that the enforcement branch conducts. State law requires the bureau to conduct investigations of some types of accidents and to consider investigating others, as the text box shows. The bureau generally must prepare evidence and findings, may coordinate with the appropriate prosecuting authorities, and can refer cases that may involve employers' criminal conduct to them. The bureau's most recent publicly available report showed that it referred 31 cases for prosecution during the four-year period from 2019 to 2022, and it closed 1,800 cases without referral during the same period.

Three of the 15 accidents we reviewed involved a fatality, and the bureau referred one to a prosecuting authority. These three fatality cases involved violations that enforcement staff had identified, so the bureau was required to investigate. However, when we asked for evidence of its investigation—such as a detailed rationale for why it had referred, or not referred, the cases for prosecution—the bureau provided documentation that contained only minimal descriptions of its reasoning, such as "insufficient evidence." Of the three fatality cases, we had concerns about the bureau's decision not to refer one of them, which we describe in Figure 13. Although prosecuting authorities such as district attorneys—and not the bureau of investigations—ultimately decide whether to take cases to court, the bureau plays an important role in referring accidents to them. When the bureau does not refer accidents that may involve criminal conduct, it risks missing an opportunity to hold employers accountable for harm and to deter other employers from putting workers at risk.

The bureau of investigations could not provide us with documentation that it had reviewed inspection reports for the four non-fatal accidents in our selection that involved enforcement branch inspections and citations; thus, there was no way for us to verify that the bureau had seen the cases. These four accidents each involved a serious violation and a serious injury and therefore required the bureau to review the case file. In one case, for example, two workers suffered amputations of a limb, and the Cal/OSHA district office identified a serious accident-related violation that remained in place even after the employer appealed and settled the case. However, we found no evidence that the bureau of investigations had received or reviewed the inspection report to consider a potential investigation. In fact, the bureau's public report shows that from 2019 through 2022, nearly all cases that it opened and that it

referred to prosecutors were fatalities. The current administrative chief of the bureau of investigations, who has been in that position since 2021, confirmed that the bureau has largely considered only fatalities for potential investigation, but she told us that the bureau is required to review and potentially investigate more non-fatality cases like the one we describe.

Figure 13
A Referral for Potential Criminal Prosecution May Have Been Warranted in a Fatality Case We Reviewed


A fuel tank, which the employer had not tested for residual gases, exploded and killed a worker.
Final Violations and Fine Amount After Appeal and Settlement:
$78,810
4 general violations
2 serious violations
1 additional serious violation classified as willful and accident-related*
BUREAU OF INVESTIGATIONS ACTION:
Did not refer to local district attorney for potential prosecution.
The bureau's documented rationale:
The bureau's records cited "insufficient evidence" but did not provide any additional details or reasoning for why it did not refer the case to the local district attorney.
The bureau confirmed that it did not have policies or procedures for documenting its case reviews, including the factors it considered in making decisions about these referrals.
Indications that a referral for prosecution may have been warranted:
The willful, accident-related violation remained in place even after appeal, suggesting that there was underlying evidence to support that the employer had at least some responsibility for the fatality.
Cal/OSHA's current chief counsel—who now also leads the bureau of investigations—told us that willful, accident-related violations in a fatality case indicate that the bureau should look closely at referring the case to prosecutors.
The enforcement branch inspector who worked on this case told us that, in their opinion, the bureau should have referred the case to the local district attorney.

Source: Case file, state law, Cal/OSHA policies and procedures, and interviews with Cal/OSHA officials.

* A *willful* violation means that, at minimum, the employer was aware that an unsafe condition existed and made no reasonable effort to eliminate the condition. An *accident-related* violation generally means that the violation caused the fatality or the injury or illness.

One potential reason that the bureau of investigations could not provide us with detailed documentation about its decisions is that it lacked sufficient policies and processes for evaluating cases. For example, Cal/OSHA's policy and procedure manual does not include policies for how the bureau should document its reviews, investigations, and decisions about whether to refer accidents to prosecutors. The administrative chief of the bureau told us that the bureau is currently developing a detailed policy and procedure manual to govern its operations. The bureau also relies on enforcement unit personnel to provide it with information about non-fatal accidents so it can review these accidents; however, there is not an efficient process for this communication. For instance, Cal/OSHA officials told us that the bureau does not have access to the current case management database that enforcement personnel use, and it instead relies on district offices to contact them each time a case may warrant the bureau's review. In the four non-fatal accident cases we discuss earlier, we did not find evidence that the district offices had notified the bureau about any of them. The administrative chief of the bureau stated that Cal/OSHA is working on an automated process for district offices to notify the bureau about non-fatal accident cases that it is required to review.

Understaffing has been another key limitation on the bureau's work. State law requires the bureau to be staffed by as many attorneys and investigators as are necessary to carry out the purposes of the statutes. However, the bureau had a total of three field investigators for the entire State from 2020 through 2022, despite processing hundreds of cases each year. The bureau has been in the process of hiring more staff since summer 2024: A 2024 organizational chart shows that the bureau had nine investigator positions filled. The bureau's chief investigator indicated that the bureau also wants to add several more positions. Bureau of investigations officials told us that these additional positions are necessary to more thoroughly review the potentially hundreds or thousands of accidents each year that may fall under the statutory provisions we describe.

Cal/OSHA Must Address Shortcomings in Its Staffing Levels and Oversight

Key Points

- Understaffing has limited Cal/OSHA's ability to enforce critical health and safety standards and protect workers. In its enforcement branch and at several district offices, Cal/OSHA had a 40 percent vacancy rate in late 2024, and the division's overall vacancy rate in fiscal year 2023–24 was 32 percent, both rates much higher than the 20 percent vacancy rate for state government positions more broadly.

- Cal/OSHA's lax management of its policies and procedures has made it difficult for district offices to comply with them. Several key policy documents have been out-of-date for years and contain inconsistent directives. Further, Cal/OSHA's reliance on paper-based case files is inefficient and has likely contributed to poor documentation and data entry errors. Routinely conducting internal audits of case files and implementing a case management system could help ensure that Cal/OSHA enforcement personnel follow policies and procedures and conduct thorough inspections.

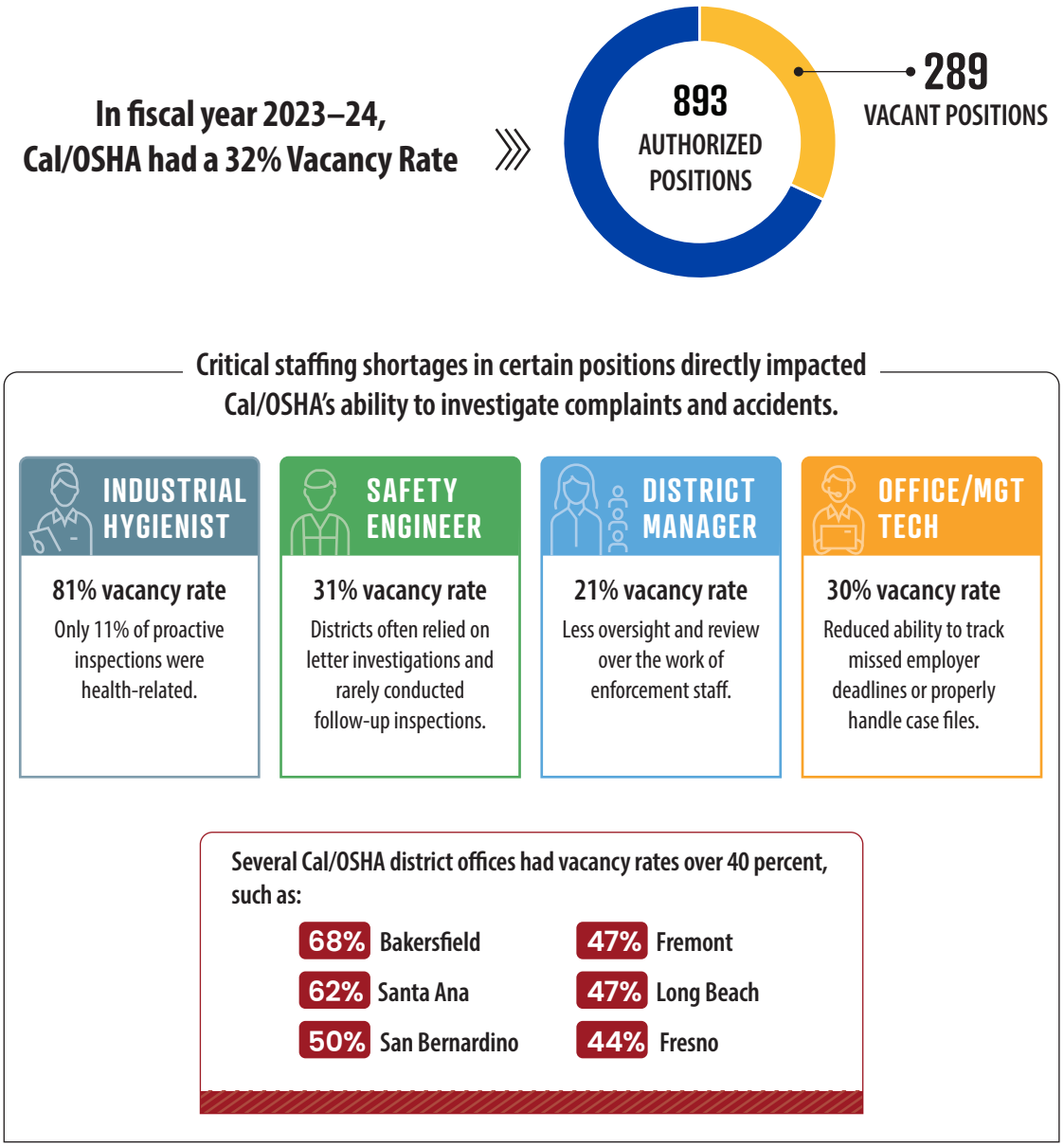
Staffing Shortages Hindered Cal/OSHA's Ability to Inspect Workplaces and Better Protect Workers

Understaffing has limited Cal/OSHA's ability to enforce critical health and safety standards and protect workers. Not only does Cal/OSHA likely need to increase the number of on-site inspections that it conducts, but even the inspections that it *did* conduct lacked important documentation. Nearly all the 24 regional and district managers we interviewed told us that their offices would have conducted more on-site inspections and inspected more thoroughly had they been adequately staffed.

As Figure 14 shows, Cal/OSHA has experienced understaffing throughout the division. In its enforcement branch and several district offices, the vacancy rate was as high as 40 percent based on data it provided from late 2024, and Cal/OSHA's overall vacancy rate in fiscal year 2023–24 was 32 percent—both rates much higher than the 20 percent statewide vacancy rate that the Legislative Analyst's Office reported for state government positions as of February 2024. These vacancies, including those of several key positions and district offices, have had negative consequences. In addition to the problems we highlight throughout this report, federal OSHA reported that Cal/OSHA had a lower enforcement presence relative to the three-year national average in 2021 and 2022,[4] generally meaning that Cal/OSHA did not conduct as many on-site inspections as other states did relative to the number of employers in each state. Further, according to a 2024 workload study of its inspector positions, Cal/OSHA had an unmet annual need of thousands of inspections related to workplace health hazards such as asbestos, lead, and other carcinogens. Industrial hygienists are specialized inspectors who generally work on health-related inspections, and a severe vacancy rate of more than 80 percent among those positions has contributed to these unmet needs for health-related inspections.

[4] In 2023, federal OSHA found Cal/OSHA's enforcement presence to be within the acceptable range compared to the three-year national average. However, it was lower than in comparable states, such as Washington and Oregon.

Figure 14
Cal/OSHA Has Had High Vacancy Rates, Including in Key Positions and District Offices


In fiscal year 2023–24, Cal/OSHA had a 32% Vacancy Rate
893
AUTHORIZED POSITIONS
289
VACANT POSITIONS
Critical staffing shortages in certain positions directly impacted Cal/OSHA's ability to investigate complaints and accidents.
INDUSTRIAL HYGIENIST
81% vacancy rate
Only 11% of proactive inspections were health-related.
SAFETY ENGINEER
31% vacancy rate
Districts often relied on letter investigations and rarely conducted follow-up inspections.
DISTRICT MANAGER
21% vacancy rate
Less oversight and review over the work of enforcement staff.
OFFICE/MGT TECH
30% vacancy rate
Reduced ability to track missed employer deadlines or properly handle case files.
Several Cal/OSHA district offices had vacancy rates over 40 percent, such as:
68% Bakersfield
62% Santa Ana
50% San Bernardino
47% Fremont
47% Long Beach
44% Fresno

Source: Cal/OSHA organizational chart, Cal/OSHA staffing data, and interviews with Cal/OSHA officials.

Cal/OSHA's vacancy rate increased during our audit period, as we explain further in Appendix B. DIR provided us with an internal report that showed a 21 percent vacancy rate for Cal/OSHA as of March 31, 2025, which would represent a significant improvement from the rate we calculated for fiscal year 2023–24. This report had not yet been finalized or reviewed by any external entities as of June 2025 and did not provide vacancy rates specific to the enforcement branch or to individual job positions. It remains to be seen whether these vacancy rate decreases persist and help address the problems we identified.

DIR and Cal/OSHA officials mentioned several challenges that contribute to Cal/OSHA's understaffing, some of which we summarize in the text box. Similar to the findings from our May 2024 audit of the Labor Commissioner's Office,[5] despite Cal/OSHA having a documented model timeline for efficient hiring, many managers and administrators expressed frustration with having lost qualified candidates because of several hiring inefficiencies. Other challenges related to pay and workload disparities have made it difficult to recruit and retain staff. Moreover, as we noted in our audit of the Labor Commissioner's Office, DIR lost its delegated authority to hire staff in April 2019 and did not regain its hiring authority until March 2021, complicating its efforts to fill positions.

Examples of Challenges in Hiring and Retaining Cal/OSHA Staff

- Too few qualified candidates apply for positions, limiting the applicant pool.
- DIR has relied on disparate systems and manual processes to manage the hiring process instead of using one centralized platform.
- A pay disparity exists between industrial hygienists and safety engineers, making it more difficult to hire and retain staff in certain industrial hygienist positions.
- Internal attrition hinders retention efforts, such as when Cal/OSHA loses enforcement staff to other DIR units that may have more manageable workloads and schedules.

Source: Interviews with Cal/OSHA managers and DIR administrators and human resources documents.

Cal/OSHA has taken steps to address its understaffing, but the results of these efforts are not yet fully clear. For example, Cal/OSHA contracted with a human resources consulting firm to complete a workload study in November 2024 for the industrial hygienist and safety engineer classifications, and it identified a need to add more positions, particularly industrial hygienists, in addition to filling the ones currently authorized for fiscal year 2024–25. The same firm is also in the process of conducting a classification study for safety engineers and industrial hygienists and plans to propose a compensation study for the district and regional manager positions. Nevertheless, DIR officials told us that the process to complete these studies and implement changes from them may take until at least 2026 and is not fully within DIR's control. To help facilitate the hiring process, Cal/OSHA created a dedicated recruitment and retention unit within the enforcement branch in May 2024. DIR has also begun the process to develop a centralized platform to manage recruitment, hiring, and retention.

The Joint Legislative Audit Committee (Audit Committee) also asked us to review the funds budgeted for vacant positions and whether Cal/OSHA used these funds for other purposes. We determined that these budgeted funds that Cal/OSHA saved because of its vacant positions totaled a little more than $23 million in fiscal year 2023–24, and about $85 million during our five-year audit period. However, determining whether or how Cal/OSHA used the savings resulting from vacant positions was not clear because DIR officials told us that the department does not track the savings separately to demonstrate how it used them. Further, Cal/OSHA receives its funding mainly from special funds rather than from the State's General Fund, and the vacancy-related savings are likely split across several special funds, making them more difficult to track. Even so, we found indications that a significant

[5] *The California Labor Commissioner's Office: Inadequate Staffing and Poor Oversight Have Weakened Protections for Workers*, Report 2023-104, May 2024.

portion of the vacancy-related savings may have simply added to unspent reserves in certain funds. For example, the largest of the special funds from which Cal/OSHA derives its revenue is the Occupational Safety and Health Fund. Upon appropriation by the Legislature, Cal/OSHA can use this fund for any activities that support its work, and unspent funding adds to the fund balance. Cal/OSHA significantly underspent its budgeted appropriations for the Occupational Safety and Health Fund during our audit period, and the balance in this fund had grown to about $201 million at the end of fiscal year 2023–24. Cal/OSHA has used the budget change proposal process to request approval for additional funding, such as for $12.6 million it requested in fiscal year 2023–24 from the Occupational Safety and Health Fund to support developing its new electronic case management system. Ultimately, the best solution for reducing unspent funds associated with vacancies is for Cal/OSHA to prioritize filling those vacancies so it has the staff it needs to better protect California workers.

Cal/OSHA Should Modernize Its Policies and Review District Offices' Compliance With Them

In addition to understaffing, problems with Cal/OSHA's policies and oversight of district offices have contributed to many of the deficiencies we identify in our report. Although we make specific recommendations for policy and procedure changes, some broader themes have contributed to policy noncompliance.

Cal/OSHA's management of its policies and procedures has made it difficult for district offices to consistently comply with them. Its policy and procedure manual currently exists on its website as a series of PDF documents, many of which are outdated or inaccurate. For example, one of the division's most widely applied policies—one that covers citations, penalty notifications, and verification of abatement—has not been updated since 2008, or 17 years ago. In another example, Cal/OSHA's accident investigation policy is listed as a "draft," includes a provision of law that became obsolete in 2020, and does not incorporate requirements from Cal/OSHA's separate heat policy, all of which may have contributed to Cal/OSHA not inspecting certain accident cases we reviewed. Further, when policy updates have occurred, the changes were sometimes communicated through individual memos instead of formal updates to the relevant policies. Some district managers told us these shortcomings meant that personnel lacked clear guidelines for their work and could not use Cal/OSHA's policies and procedures to train new staff. Additionally, the case files we reviewed contained different versions of standard forms, such as Cal/OSHA's complaint and accident intake forms. Cal/OSHA hired a policy writer in July 2024 to update its policies and procedures and to manage the policy update process in the future. By regularly reviewing and updating its policies and forms, Cal/OSHA can ensure that these documents are current, consistent, and useful for staff.

As part of its monitoring requirements, federal OSHA expects Cal/OSHA to operate an effective internal self-audit program. To meet this expectation, the Cal/OSHA policy that was effective during our audit period required each district office to undergo an annual case file audit, which regional office staff from other regions

were to perform. However, Cal/OSHA did not consistently conduct recurring audits of its case files, which limited its ability to assess the policies' effectiveness, to determine whether staff applied them consistently, and to make improvements. A 2023 review by DIR found that the summary report of these audits for federal fiscal year 2020–21 was incomplete, inconsistent, and never finalized, resulting in potential missed opportunities for improvement. Further, some regional managers told us that Cal/OSHA did not perform the audits consistently for reasons such as understaffing, other priorities taking precedence, and the effects of the COVID-19 pandemic. As a result of DIR's 2023 review, Cal/OSHA decided to move responsibility for conducting these audits to DIR's centralized internal audit unit, although Cal/OSHA has not updated its policy to reflect the change. This DIR unit has already conducted several internal audits that identified many of the same problems we observed, such as inspection case files that were not always complete. However, these internal audits have not yet examined other important elements of case management, such as district offices' justifications for not conducting on-site inspections of complaints and accidents.

Finally, Cal/OSHA's reliance on hard copy case files is inefficient and increases its risk of poor documentation and data entry. For example, when we requested one accident case file, the district manager told us that the file had been accidentally shredded because of a mix-up that resulted from understaffing and having dozens of boxes of case files to process. As a result, it was difficult for us to evaluate whether Cal/OSHA had adequate justification for not inspecting the accident. Cal/OSHA plans to implement a new case file management system by November 2027, although the project has already faced multiple delays. According to Cal/OSHA's analysis of the project, the new system is necessary to automate its current manual processes and will provide enhanced case management, including electronic document storage and automated upload of manual forms. Cal/OSHA expects to reduce the number of new paper case files created by 90 percent within the first year of implementing its new system. The analysis also states that the system will provide more reliable and efficiently entered data that can reduce data entry errors and help improve decision-making.

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Other Areas We Reviewed

Cal/OSHA Could Better Protect Workers With a More Streamlined Process for Submitting Complaints

Because Cal/OSHA does not have its own online complaint submission form or portal, it can be difficult for workers to submit complaints and for Cal/OSHA to receive them. As Figure 15 shows, Cal/OSHA directs workers to call or email their local district office to file a complaint. Its website instructs complainants to submit as much information as possible and contains a long list of suggested items to include. Among that long list are details such as the work hours of management, a description of the personal protective equipment the employer has provided, and any tests conducted by the employer to determine whether the condition is hazardous. Alternatively, complainants may file a complaint using the federal OSHA online complaint form. Complaints submitted using the federal form are automatically forwarded to a central Cal/OSHA office, and the central office then forwards the notification to the appropriate district office. However, of the 22 states and territories that operate their own OSHA programs, California is one of only two—the other being Puerto Rico—that do not include a link to any online complaint portal on their OSHA division's website. Cal/OSHA is in the process of developing an online system to better manage its data, including a means to allow users to file complaints online.

In addition to making it easier to submit complaints, an online complaint submission portal could help ensure that Cal/OSHA accurately captures and responds to all of a complainant's concerns. Several case files we reviewed listed the origin of the complaint as a phone call and did not contain a full transcript or written record of the original complaint, raising questions about whether Cal/OSHA had accurately understood and responded to all of the complainant's concerns. In fact, even when complainants use the federal portal, there can be inaccuracies. According to Cal/OSHA policy, when a district office receives a complaint that originated from the federal portal, staff copy the complaint information onto a specific form and then manually create a new record in the federal database that Cal/OSHA currently uses to manage case information. A 2023 internal audit found that Cal/OSHA staff reworded or summarized 77 percent of sampled complaints submitted online, generally capturing elements of the original hazard descriptions but leaving out certain details.

A streamlined online complaint portal could also help Cal/OSHA respond to complaints more efficiently. For example, if Cal/OSHA designed an online complaint portal to automatically populate its complaint form and database, district office staff could focus on evaluating the substance of the complaint and gathering additional details instead of spending time on manual data entry. Cal/OSHA could also consider ways to automatically refer online complaints to the appropriate district office by using the worksite location included in the complaint, instead of requiring the complainant to identify and contact the correct Cal/OSHA district office. Integrating these features into its own online complaint portal could allow Cal/OSHA to better use its limited staff.

Figure 15
Cal/OSHA Currently Lacks an Online Complaint Submission Form or Portal

Excerpt from Cal/OSHA's complaint webpage as of June 2025:

How to File a Complaint:

Contact the District Office

If you would like to report workplace safety or health hazards to Cal/OSHA, choose one of the following:

- **Telephone** the Cal/OSHA Enforcement District Office closest to your worksite between 8 am and 5 pm Monday through Friday except state holidays. Cal/OSHA staff can discuss your complaint and respond to any questions you have.
- **Email** the Cal/OSHA Enforcement District Office closest to your worksite. Cal/OSHA will receive your email during regular business hours and will contact you if there are questions about the complaint.

For assistance finding the closest enforcement district office in Regions 1, 2, 3 or 4 that serves your job location, use the Cal/OSHA Enforcement district office locator

Excerpts from other states' online complaint forms as of June 2025:

NORTH CAROLINA

Type of Business *

Hazard Description *

Describe briefly the hazard(s) which you believe exist. Include the approximate number of employees exposed to or threatened by each hazard.

Hazard Location *

Specify the particular building or work site where the alleged violation exists.

OREGON

Which of the following describes you? * --- Select One ---

First Name First Name

Last Name Last Name

Your Email Address Your Email Address

Retype Email Address Retype Email Address

Telephone Telephone

Mailing Address Mailing Address

City, State, ZIP City

Oregon ZIP (5 digits)

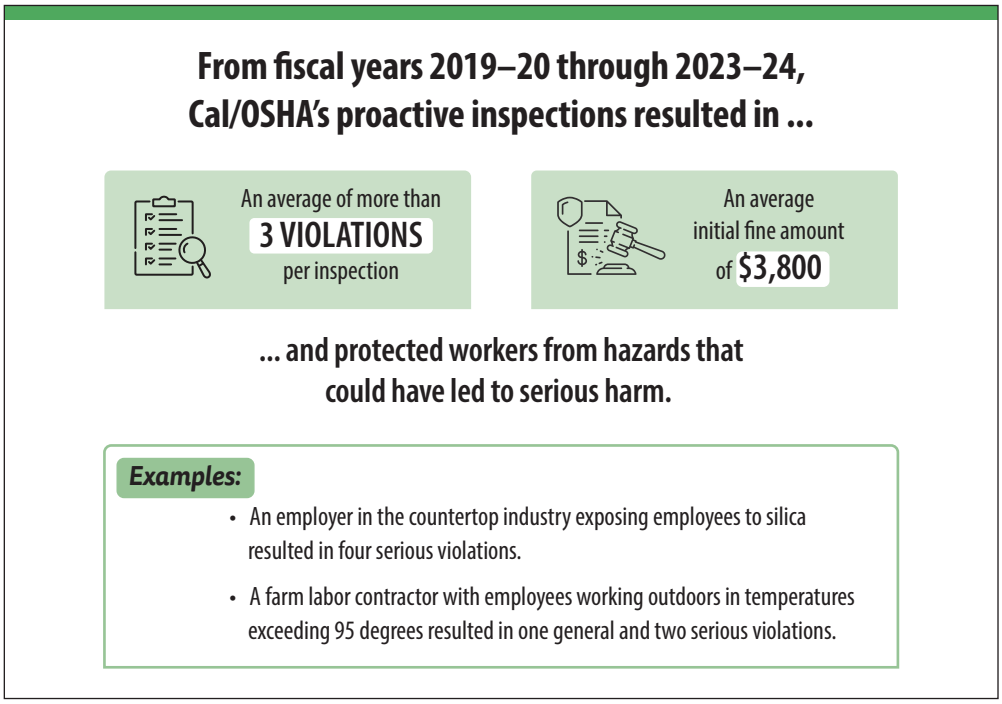
Source: Cal/OSHA webpage and webpages from North Carolina and Oregon state governments.

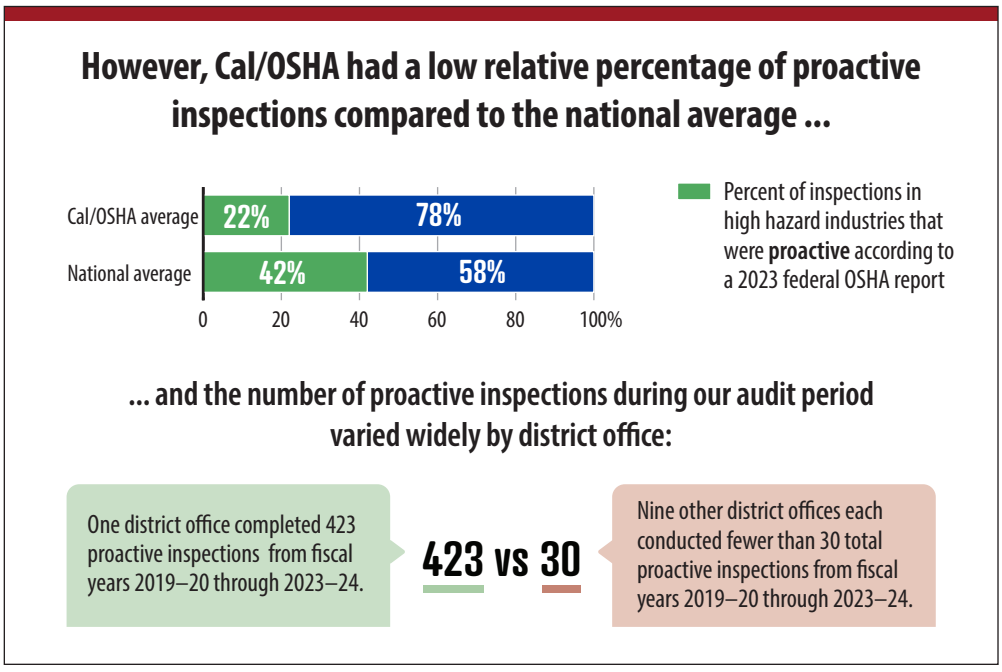
Conducting Additional Proactive Inspections Could Help Cal/OSHA Reduce the Number of Complaints It Receives and Prevent Accidents From Occurring

In its efforts to help identify potential hazards before they cause a serious injury or illness, Cal/OSHA conducts programmed inspections (proactive inspections) of employers in specific industries with high rates of preventable injuries, the potential to expose employees to a hazardous substance, or specific risks such as in construction or tree trimming. Regional and district managers also told us that proactive inspections can encourage employers to comply with standards and provide an opportunity to educate workers about workplace safety and health. Figure 16 shows that, despite these benefits, the percentage of Cal/OSHA's inspections that were proactive was much lower than the national average. From fiscal years 2019–20 through 2023–24, only about 20 percent of Cal/OSHA's inspections were proactive. Although we are not suggesting that Cal/OSHA should conduct additional proactive inspections at the expense of other types of inspections that its policy currently prioritizes, such as most types of complaint and accident inspections, it should nevertheless plan to significantly increase the number of proactive inspections it conducts and work toward obtaining the resources necessary to do so.

Cal/OSHA has two types of offices that handle proactive inspections: specialized offices that focus entirely or more acutely on proactive inspections, such as the high hazard unit; and district offices that conduct proactive inspections in addition to those for all types of complaints or accidents. Except in 2021, the high hazard unit met federal OSHA's strategic goals for proactive inspections during our audit period. It may have met the goals because they are clear, or it may be that the unit has detailed methods for targeting employers or that there exist statutory requirements that it maintain sufficient personnel. It was less clear whether other specialized units met their proactive inspection goals. For example, state law requires that the mining and tunneling offices conduct 11 inspections of a specific type each year. We found that they conducted over a hundred proactive inspections in each of the audit years, but the data was not specific enough for us to determine which of the inspections met the statutory requirements. District offices also proactively inspect employers as part of a special emphasis program—such as programs related to heat or silica—or when employers notify Cal/OSHA of certain activity, such as using asbestos or obtaining new construction permits. The district offices received hundreds of notifications from employers each year that they could have inspected. However, offices sometimes conducted few of these inspections relative to the number of notifications they received. In addition, as Figure 16 shows, the number of proactive inspections that each district office conducted varied widely.

Figure 16
Workers Would Benefit From Cal/OSHA Performing Additional Proactive Inspections


From fiscal years 2019–20 through 2023–24, Cal/OSHA's proactive inspections resulted in ...
An average of more than 3 VIOLATIONS per inspection
An average initial fine amount of $3,800
... and protected workers from hazards that could have led to serious harm.
Examples:
• An employer in the countertop industry exposing employees to silica resulted in four serious violations.
• A farm labor contractor with employees working outdoors in temperatures exceeding 95 degrees resulted in one general and two serious violations.


However, Cal/OSHA had a low relative percentage of proactive inspections compared to the national average ...
Cal/OSHA average
22%
78%
National average
42%
58%
0
20
40
60
80
100%
Percent of inspections in high hazard industries that were proactive according to a 2023 federal OSHA report
... and the number of proactive inspections during our audit period varied widely by district office:
One district office completed 423 proactive inspections from fiscal years 2019–20 through 2023–24.
423 vs 30
Nine other district offices each conducted fewer than 30 total proactive inspections from fiscal years 2019–20 through 2023–24.

Source: Federal OSHA reports, Cal/OSHA inspection data, interviews with Cal/OSHA managers, and district office case examples.

State law, federal grant requirements, and its own policies and procedures provide Cal/OSHA with proactive inspection goals and guidelines; however, they are not always clear or consistent. For instance, state law requires that employers notify Cal/OSHA when they plan to undertake certain permitted activity, such as digging a trench that is five or more feet deep, but state law does not mandate that Cal/OSHA then proactively inspect those worksites. Regional and district managers told us that goals for proactive inspections vary by district office and that they are not tracked at the division level. Without clear and consistent guidelines for how many employers to inspect proactively, managers may not devote as many resources toward those efforts. Managers also told us that they do not have access to up-to-date resources, such as databases of employers, to know which worksites to inspect. As a result, managers described relying on out-of-date employer lists or even driving around an area to search for worksites to inspect. According to one regional manager, approaches like these can take an inordinate amount of time away from conducting inspections. Moreover, it may decrease the likelihood that Cal/OSHA selects the employers or worksites that are most beneficial to inspect. These inefficiencies are especially problematic because understaffing means that Cal/OSHA has limited resources to conduct proactive inspections in the first place. Setting consistent and reasonable goals and giving district offices a method to easily identify worksites to inspect would better position Cal/OSHA to conduct additional proactive inspections and better protect workers.

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Recommendations

Cal/OSHA

To ensure that enforcement personnel conduct on-site inspections of complaints when circumstances warrant inspections, Cal/OSHA should, by July 2026, revise its policies and procedures in the following ways:

- Require personnel to provide a thorough rationale—for example, more than a short phrase—that explains how their decision not to conduct an on-site inspection aligns with specific policy requirements. Cal/OSHA should also specify how or where personnel should document this rationale in the case file.

- Place more emphasis on factors other than the source of a complaint when determining whether to inspect on-site—such as the severity of the allegations, the employer's history, and the potential benefits or drawbacks of an on-site inspection relative to the circumstances of the complaint—and specify that personnel should not investigate a complaint by letter simply because the complainant wishes to remain anonymous.

- Describe the steps personnel should take, such as contacting the regional manager to try to obtain additional resources, when staffing shortages may limit a district office's ability to inspect a complaint on-site.

To ensure that letter investigations effectively address hazards, Cal/OSHA should, by July 2026, revise its policies and procedures in the following ways:

- Explicitly require enforcement personnel to include supporting documents from employers, in addition to employers' written responses, in the case file before closing a letter investigation. These supporting documents should prove that employers have adequately responded to each alleged hazard. Cal/OSHA should also ensure that personnel evaluate the employer responses and supporting documents consistently, such as by providing guidelines or training for doing so.

- Outline a method to verify that employers receive Cal/OSHA's letters in a timely manner, such as by instructing personnel to send letter investigations to employers by email and to document when the employers received them. If personnel do not have an email address for the employer, Cal/OSHA should consider requiring personnel to call the employer to verify the mailing address.

- Clarify that district offices should conduct the follow-up inspections of satisfactory employer responses that are currently optional, unless the offices notify enforcement branch leadership or otherwise document that they do not have enough staff available to do the inspections.

To ensure that it makes appropriate decisions about which accidents to investigate, Cal/OSHA should, by July 2026, update its policies and procedures to include the factors that personnel should consider when determining whether to investigate a reported accident and how to appropriately explain and document these factors in the case file. These factors should include, at a minimum, the following:

- Whether state law or other Cal/OSHA policies require an investigation. Cal/OSHA should also specify how to document this factor, such as by including in the case file medical records or other evidence proving that a worker did not suffer a serious injury or illness or by including a rationale for why an investigation of a serious injury or illness is unnecessary.

- Whether an investigation would be beneficial even if one is not mandatory. For example, personnel could consider the likelihood that an inspection would identify workplace violations and help prevent future accidents, and they could weigh the potential benefits of an inspection against the district office's other priorities. As part of these policy revisions, Cal/OSHA should explicitly include a process for investigating reported accidents that do not meet the threshold of a serious injury or illness in state law, such as by including these types of cases in its prioritized list of on-site inspection types.

To improve its evaluation of employers' injury and illness prevention programs (IIPPs) and to ensure that these programs adequately protect workers, Cal/OSHA should, by July 2026, revise its policies and procedures to specify how personnel should document IIPP evaluations in the case file. Such procedures should include how personnel should document an assessment of the employer's written IIPP and of the employer's implementation of the IIPP in practice. Cal/OSHA should also consider distributing to enforcement personnel a unified form or template for documenting a thorough IIPP evaluation.

To ensure that enforcement personnel interview an adequate sample of employees, Cal/OSHA should, by July 2026, revise its policies and procedures to clarify how personnel should determine the number and type of employees to interview.

To ensure that enforcement personnel document interviews effectively, Cal/OSHA should, by July 2026, provide training or take other steps to ensure that personnel are aware of its interview documentation policies and either record audio of interviews, obtain signed statements from workers, or take legible notes. In addition, Cal/OSHA should revise its policy to require enforcement personnel to document in the case file when a worker has declined Cal/OSHA's request to record an interview.

To ensure that case files include the evidence necessary to support the citations it issues, Cal/OSHA should, by July 2026, establish a policy or process for enforcement personnel to internally review and discuss the evidence supporting potential violations in each on-site inspection while there is still time to gather additional evidence, such as at the two- or three-month mark of a six-month inspection. These reviews should include the violation worksheets and evidence supporting potential violations. Cal/OSHA should also develop a method for tracking these reviews, such as automated reminders to have them.

To ensure that it conducts on-site inspections in a timely manner, Cal/OSHA should, by July 2026, revise its policies and procedures to establish and implement goal time frames in which it expects personnel to initiate inspections of non-fatal accidents and of complaints—other than *imminent hazard* complaints—that fall outside of the purview of Labor Code section 6309.

To ensure that employers abate hazardous conditions that Cal/OSHA's inspections identify, Cal/OSHA should, by July 2026, revise its policies and procedures to require enforcement personnel to do the following:

- Request and document in the case file supporting evidence beyond signed certifications—such as photographs, detailed inspector observations, or other records—proving that the employer abated each violation that Cal/OSHA classifies as serious, repeat, or willful. Cal/OSHA should also consider whether such supporting evidence of abatement is advisable for non-repeat and non-willful general violations and, to the extent Cal/OSHA deems it necessary, request changes to state law or regulations to grant it the authority to request this evidence from employers.

- Document in each accident case file the accident's causes or contributing factors that enforcement personnel have uncovered during the inspection and, when the causes or factors are reasonably related to a workplace violation, document an explanation of how the employer's abatement efforts have addressed each of these causes or factors and mitigated the likelihood of future accidents occurring. Cal/OSHA should require that personnel document these items even for accidents that occurred at temporary worksites.

To ensure that it assesses fines appropriately, Cal/OSHA should, by July 2026, revise its policies and procedures to require the following:

- Enforcement personnel must document rationales and evidence supporting the classifications and adjustment factors they apply for each fine—including rationales supporting that a violation is or is not accident-related—and specify where in the case file personnel should provide this information. For example, Cal/OSHA could require that personnel use the existing violation worksheets but include specific reasoning to support each classification and factor.

- Staff must document rationales for all post-citation fine reductions, including those made outside of an informal conference meeting, and must also document supporting evidence when it helps demonstrate the reasonableness of the reductions. Cal/OSHA should specify whether these rationales and supporting evidence should be documented in the enforcement case file or whether some rationales that are protected by attorney-client privilege can be maintained in the legal unit's files.

To ensure that the bureau of investigations refers cases for potential criminal prosecution whenever warranted, Cal/OSHA should, by July 2026, do the following:

- Establish written policies or procedures for how the bureau reviews cases, decides whether to investigate them, and decides whether to refer them for prosecution. The guidelines should require that the bureau document a rationale for why it has decided not to investigate or not to refer each case.

- Establish a routine or automated process for the bureau to receive information about accident cases with non-fatal injuries so that it can review them in accordance with requirements in state law.

To increase its staffing levels and ensure that it can adequately protect workers, DIR should document and implement a plan for requesting additional authorized positions as needed and reducing vacancy rates within Cal/OSHA's enforcement branch to 20 percent or less by July 2027. The plan should aim to do the following, at minimum:

- Use the 2024 workload study results and the results of our audit to ensure that Cal/OSHA has requested the number of authorized positions necessary to adequately enforce workplace health and safety standards.

- Address key barriers to filling authorized positions and retaining staff, such as by implementing its planned centralized system for managing the hiring process, building career pipelines for safety engineers and industrial hygienists through outreach or other efforts, and making efforts to reduce pay disparities for key positions.

To modernize its policies and procedures, Cal/OSHA should, by July 2026, take the following actions:

- Formalize a process for reviewing and updating its policies and procedures at least every three years, including any standard forms or templates that its policies require. The process for reviews should include requesting and incorporating feedback from enforcement personnel at district offices.

- Ensure that policies are easily accessible to staff. For example, Cal/OSHA should consider establishing a more user-friendly, searchable manual of its policies if doing so would be helpful for enforcement personnel.

To ensure that enforcement personnel implement its policies correctly and consistently in practice, Cal/OSHA should work with DIR's internal audit team to develop a policy or process for conducting recurring audits that examine enforcement branch case files. The policy or process should specify that the audits evaluate whether case files contain at least the following elements, and the first audit should be completed by July 2026:

- Clear rationales for decisions not to inspect complaints and accidents.

- Detailed analyses of employers' IIPPs, a sufficient number and type of employee interviews, appropriate recordings or notes from those interviews, and complete analyses in violation worksheets for each violation identified.

- Supporting evidence that employers have abated each violation.

- Clear rationales for initial fine classifications and adjustment factors and for post-citation fine reductions.

To more consistently, accurately, and efficiently perform its work, Cal/OSHA should, by July 2027, develop and implement an electronic case management system that allows it to maintain and manage case files digitally rather than in hard copy. Cal/OSHA should consider developing the system in such a manner that it alerts personnel to any missing documents before allowing personnel to close each case in the system.

To make it easier for workers to submit complaints, Cal/OSHA should, by January 2027, develop and implement a tool or portal that allows complainants to submit complaints online directly to Cal/OSHA.

To ensure that it conducts as many proactive inspections as are feasible, Cal/OSHA should, by July 2026, do the following:

- Consider whether consolidating proactive inspection responsibilities within specialized offices such as the high hazard unit—as opposed to also requiring traditional district offices to conduct them—would increase efficiency and effectiveness for these inspections.

- Specify proactive inspection goals for each type of proactive inspection that enforcement personnel conduct. For example, Cal/OSHA could establish goals for each type of proactive inspection and work with enforcement offices to ensure the goals are reasonable given the offices' staffing and workloads.

- Document a process or methodology for how enforcement personnel should select which employers or worksites to proactively inspect. For example, Cal/OSHA could create and regularly update a list or database of potential proactive inspections to conduct that is ordered by priority and accessible to enforcement personnel.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code section 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

GRANT PARKS
California State Auditor

July 17, 2025

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Appendix A

Cal/OSHA's Enforcement Activity, Fiscal Years 2019–20 Through 2023–24

Statistics on Cal/OSHA's Complaint Process

The Audit Committee directed our office to determine the number and nature of workplace complaints that Cal/OSHA received for the most recent five years, including the industry types against which workers filed complaints and the number of workplace complaints that Cal/OSHA inspected and those that resulted in a fine. In addition, the Audit Committee directed our office to determine the total and average amount of fines assessed and collected and the average time from the receipt of a complaint to initiating an inspection and to closing the complaint. The following nine tables provide these statistics.

Table A.1
The Categories of Complaints, Accidents, and Referrals Cal/OSHA Received

	FISCAL YEAR					
	2019–20	2020–21	2021–22	2022–23	2023–24	TOTAL
Complaints	**13,822**	**16,308**	**11,978**	**11,961**	**12,276**	**66,345**
Health	6,730	11,346	6,096	4,557	5,042	33,771
Safety	4,030	2,595	3,597	4,392	4,976	19,590
Health and Safety	1,310	845	800	915	930	4,800
Unknown	1,752	1,522	1,485	2,097	1,328	8,184
Accidents*	**8,519**	**10,219**	**7,738**	**6,166**	**5,819**	**38,461**
Referrals†	**577**	**773**	**667**	**555**	**620**	**3,192**
Health	97	281	212	171	217	978
Safety	366	313	407	326	343	1,755
Health and Safety	105	176	47	57	59	444
Unknown	9	3	1	1	1	15

Source: Cal/OSHA data.

* Cal/OSHA typically does not separately categorize the nature of accidents as being health-related or safety-related.

† Cal/OSHA distinguishes referrals from complaints according to the source of the information it receives about potentially hazardous workplace conditions. For example, referrals may originate from nongovernmental organizations, such as news media entities, or from Cal/OSHA enforcement personnel observing a hazard themselves.

Table A.2
The Severity of Complaints, Accidents, and Referrals Cal/OSHA Received

	FISCAL YEAR					
	2019–20	2020–21	2021–22	2022–23	2023–24	TOTAL
Complaints	**13,822**	**16,308**	**11,978**	**11,961**	**12,276**	**66,345**
Imminent	183	118	61	121	175	658
Serious	941	3,684	1,785	757	942	8,109
Other	10,946	10,984	8,647	8,986	9,831	49,394
Unknown	1,752	1,522	1,485	2,097	1,328	8,184
Accidents*	**8,519**	**10,219**	**7,738**	**6,166**	**5,819**	**38,461**
Referrals	**577**	**773**	**667**	**555**	**620**	**3,192**
Imminent	21	18	17	11	30	97
Serious	116	139	68	66	87	476
Other	431	613	581	477	502	2,604
Unknown	9	3	1	1	1	15

Source: Cal/OSHA data.

Note: We categorized complaints and referrals based on their highest level of severity. For example, if a complaint was for an *imminent health and serious safety* concern, we categorized the complaint as *imminent*.

* Cal/OSHA generally does not categorize the severity of accidents.

Table A.3
Industry Type for Complaints Cal/OSHA Received

	FISCAL YEAR					
INDUSTRY TYPE	**2019–20**	**2020–21**	**2021–22**	**2022–23**	**2023–24**	**TOTAL**
Retail Trade	1,711	2,761	1,681	1,732	1,745	9,630
Health Care and Social Assistance	2,144	2,256	1,446	1,374	1,444	8,664
Accommodation and Food Services	1,109	1,695	1,472	1,300	1,362	6,938
Manufacturing	1,526	1,710	1,200	1,283	1,214	6,933
Construction	1,599	1,347	1,027	1,086	1,122	6,181
Transportation and Warehousing	1,080	1,224	887	958	977	5,126
Administrative and Support and Waste Management and Remediation Services	690	698	493	597	613	3,091
Public Administration	577	761	572	522	493	2,925
Other Services (except Public Administration)	575	682	517	533	609	2,916
Educational Services	474	521	603	498	570	2,666
Wholesale Trade	559	619	445	477	526	2,626
Agriculture, Forestry, Fishing and Hunting	456	433	344	305	319	1,857
Professional, Scientific, and Technical Services	297	443	351	305	265	1,661
Arts, Entertainment, and Recreation	238	391	324	323	377	1,653
Real Estate and Rental and Leasing	290	296	223	269	247	1,325
Information	164	143	131	127	127	692
Finance and Insurance	150	184	124	101	97	656
Utilities	86	63	77	88	121	435
Unknown	64	42	35	32	20	193
Mining, Quarrying, and Oil and Gas Extraction	28	25	17	45	24	139
Management of Companies and Enterprises	5	14	9	6	4	38
Totals	**13,822**	**16,308**	**11,978**	**11,961**	**12,276**	**66,345**

Source: Cal/OSHA data.

Note: About 3 percent of complaints listed more than one industry type. For these complaints, we only included the first industry type listed.

Table A.4
Workplace Complaints

	FISCAL YEAR				
	2019–20	2020–21	2021–22	2022–23	2023–24
Total valid complaints	**11,232**	**13,695**	**9,879**	**9,423**	**10,632**
Valid complaints that Cal/OSHA inspected	1,962	1,703	1,641	1,678	1,784
Percent of valid complaints that Cal/OSHA inspected	17%	12%	17%	18%	17%
Valid complaints Cal/OSHA investigated by letter	9,583	12,179	8,355	7,820	8,904
Valid complaints that Cal/OSHA did not inspect or investigate by letter	14	52	47	78	77
Total invalid complaints	**2,590**	**2,604**	**2,095**	**2,536**	**1,626**

Source: Cal/OSHA data.

Note: Cal/OSHA can review a single complaint with both a letter investigation and an inspection. Therefore, some complaints are counted in both the letter investigation and inspection totals.

Table A.5
Inspections That Resulted in Cal/OSHA Issuing Citations and Collecting Fines by Fiscal Year

	FISCAL YEAR				
	2019–20	2020–21	2021–22	2022–23	2023–24
Number of inspections	7,004	6,030	6,496	6,838	6,959
Total number of inspections with fines	4,713	3,883	4,591	4,754	4,350
Percent of inspections with fines	67%	64%	71%	70%	63%
Total amount of fines initially assessed	$40,701,251	$39,273,467	$37,042,463	$38,840,344	$34,140,575
Average amount of fines initially assessed	$8,636	$10,114	$8,068	$8,170	$7,848
Total amount of fines currently assessed*	$28,263,732	$28,073,456	$29,054,940	$32,625,686	$30,661,962
Average amount of fines currently assessed*	$5,997	$7,230	$6,329	$6,863	$7,049
Total amount of fines collected*	$20,483,711	$16,704,202	$16,441,149	$14,405,201	$7,978,614
Average amount of fines collected*	$4,346	$4,302	$3,581	$3,030	$1,834

Source: Cal/OSHA data.

Note: In our report section about fine reductions that begins on page 39, we discuss reasons that the total amounts of fines Cal/OSHA currently assessed are lower than the amounts they initially assessed. In addition, there are several possible reasons that the total amounts of fines Cal/OSHA collected are lower than the amounts they currently assessed. For example, cases can sometimes take multiple years to resolve, and employers can sometimes obtain payment plans that further extend the fine payment timeline by multiple years, meaning that Cal/OSHA may still be in the process of collecting some of the fines shown in Table A.5. These delays are likely one reason that the total amount of collected fines is much lower in fiscal year 2023–24 than in fiscal year 2019–20. In addition, when employers are delinquent in paying fines, the process for collecting those fines can be complex and involve other state agencies and superior courts. Further, some fines may end up being uncollectible for various reasons, such as if employers file for bankruptcy.

* The amounts are as of November 2024.

Table A.6
For Complaints That Resulted in a Letter Investigation: Statistics on the Number of Days From Complaint Receipt Until Case Closure

	FISCAL YEAR				
	2019–20	2020–21	2021–22	2022–23	2023–24
Number of valid complaints that resulted in a letter investigation and were closed*	9,551	11,457	7,891	6,609	6,997
Average number of days from receipt of valid complaint to close	153	136	128	95	70
Median number of days from receipt of valid complaint to close	46	53	60	46	37
Number of valid complaints that resulted in a letter investigation and were open as of November 2024*	32	720	464	1,205	1,904

Source: Cal/OSHA data.

* The total number of valid complaints that resulted in a letter investigation in this table is not an exact match to the numbers presented in Table A.4 because we removed investigations with illogical dates from the data to conduct this analysis.

Table A.7
For Complaints That Resulted in an Inspection: Statistics on the Number of Days Between Complaint Receipt and Inspection Start

	FISCAL YEAR				
	2019–20	2020–21	2021–22	2022–23	2023–24
Number of valid complaints that resulted in an inspection and had an inspection start date*	1,851	1,497	1,529	1,539	1,676
Average number of days from receipt of valid complaint to inspection start	26	33	28	23	17
Median number of days from receipt of valid complaint to inspection start	8	12	11	8	7
Number of valid complaints that resulted in an inspection and did not have an inspection start date as of November 2024*	39	40	31	42	47

Source: Cal/OSHA data.

* The number of complaints received in this table is not an exact match to the numbers presented in Table A.4 because we removed complaints with illogical dates from the data to conduct this analysis.

Table A.8
For Complaints that Resulted in an Inspection: Statistics on the Number of Days Between Complaint Receipt and Inspection Close

	FISCAL YEAR				
	2019–20	2020–21	2021–22	2022–23	2023–24
Number of valid complaints that resulted in an inspection and had an inspection close date*	1,877	1,634	1,578	1,584	1,594
Average number of days from complaint receipt to inspection close	144	164	139	131	118
Median number of days from complaint receipt to inspection close	150	167	147	142	126
Number of valid complaints that resulted in an inspection and did not have an inspection close date as of November 2024*	83	67	60	93	188

Source: Cal/OSHA data.

* The number of complaints received in this table is not an exact match to the numbers presented in Table A.4 because we removed complaints with illogical dates from the data to conduct this analysis.

Table A.9
For Complaints that Resulted in an Inspection: Statistics on the Number of Days Between Complaint Receipt and Inspection Start by Complaint Severity

	FISCAL YEAR				
	2019–20	2020–21	2021–22	2022–23	2023–24
Total number of valid imminent complaints that had an inspection start date*	172	104	57	113	152
Average number of days to open valid imminent complaints	1	1	1	1	1
Percent of valid imminent complaints opened after 2 days	6%	8%	9%	10%	9%
Total number of valid serious complaints that had an inspection start date*	395	484	459	345	447
Average number of days to open valid serious complaints	19	27	18	8	7
Percent of valid serious complaints opened after 6 days	25%	50%	45%	22%	25%
Total number of valid other complaints that had an inspection start date*	1,284	909	1,013	1,081	1,077
Average number of days to open valid other complaints	32	39	35	30	24
Percent of valid other complaints opened after 15 days	40%	50%	45%	41%	41%

Source: Cal/OSHA data.

* The number of complaints received in this table is not an exact match to the numbers presented in Table A.4 because we removed complaints with illogical dates and those without an inspection start date from the data to conduct this analysis.

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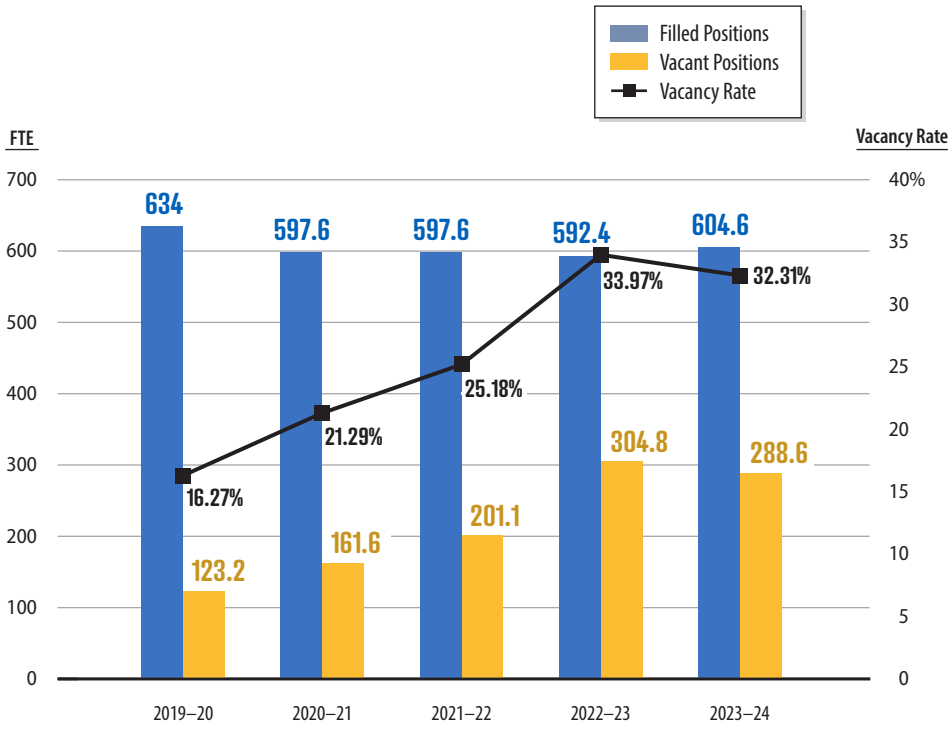
Appendix B

Staffing and Vacancy Rates, Fiscal Years 2019–20 Through 2023–24

The Audit Committee requested that we determine the number of Cal/OSHA positions authorized for the most recent fiscal year and the number of vacant positions. Figure B shows that Cal/OSHA's vacancy rate generally increased during the audit period, with a slight decrease in fiscal year 2023–24.

Figure B
Cal/OSHA's Vacancy Rate Increased From Fiscal Years 2019–20 Through 2023–24



Source: Schedule 7A documents from the Department of Finance's website.

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Appendix C

Scope and Methodology

The Audit Committee directed the California State Auditor to conduct an audit of Cal/OSHA's oversight and enforcement efforts, including how it handles workplace health and safety complaints. Table C lists the objectives that the Audit Committee approved and the methods we used to address them. Unless otherwise stated in the table or elsewhere in the report, statements and conclusions about items selected for review should not be projected to the population.

Table C
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed and evaluated federal and state laws and regulations related to workplace health and safety.
2	To the extent data are available, review Cal/OSHA's complaint process to determine the following for the most recent five years: • The number of workplace complaints that Cal/OSHA received. • The nature of the complaints Cal/OSHA received. • The employers or the industry types against which workers filed complaints. • The demographics, including race or ethnicity, age, gender, and immigration status, of the workers making complaints. • The number of workplace complaints that Cal/OSHA investigated. • The number of complaints Cal/OSHA investigated that resulted in a citation and whether a fine was assessed, the number of resulting fines for which some amounts were collected, and the proportion of the amount of fines assessed and amount of fines collected. • The average amount of fines issued and collected. • The average time from the receipt of a complaint to initiating an investigation, and to closing the complaint.	• Obtained complaint process data from Cal/OSHA for fiscal years 2019–20 through 2023–24 and performed analyses to calculate relevant statistics. • We were unable to analyze the demographics, including race or ethnicity, age, gender, and immigration status of workers making complaints because Cal/OSHA does not collect this information.

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AUDIT OBJECTIVE	METHOD
3 To the extent data are available, review and assess Cal/OSHA's process for investigating complaints by performing the following: • Review how Cal/OSHA determines which cases to investigate, including how it determines which cases will receive an investigation by letter and which will undergo on-site investigation. • For a selection of complaints that were not investigated, determine the validity of Cal/OSHA's reasoning. • For a selection of complaints that it did investigate, determine whether Cal/OSHA followed its process for investigation and the reasons for any delays.	• Documented key criteria for evaluating Cal/OSHA's complaint investigation process, such as its policies for classifying complaints and deciding whether to conduct on-site inspections. • Using a haphazard process, selected 25 complaints that did not result in an on-site inspection and then adjusted the selection to ensure that it contained appropriate numbers of cases by year, type, and district office. Judgmentally selected five additional complaints to analyze, for a total of 30 complaints, based on the circumstances of specific cases that seemed likely to strengthen our selection. For example, these additional five complaints included alleged hazards that Cal/OSHA had classified as *serious* but investigated by letter anyway. • Evaluated the 30 uninspected complaints to determine whether Cal/OSHA provided valid reasons for not inspecting the complaints on-site, based on its policies and other selected criteria. For complaints that Cal/OSHA investigated by letter, we also reviewed whether Cal/OSHA followed the process outlined in its policies to ensure that employers addressed the alleged hazards and did so within a reasonable amount of time. • Selected 15 complaints that Cal/OSHA inspected on-site and ensured that this selection covered a range of years, industries, regions, hazard types and severity levels, fine amounts, and case outcomes. For example, we made sure that our selection contained some cases with no citations and others with varying amounts of initial fines and post-citation fine reductions. We did not design our selection to be representative of the overall population of complaint inspections, but rather to position us to respond to the audit objectives and to make appropriate findings and recommendations. • Evaluated the 15 selected complaint inspections to determine whether Cal/OSHA followed key processes outlined in state law and its own policies and procedures, including whether it handled the cases within a reasonable amount of time. • Interviewed regional and district managers to obtain their perspectives on the issues we identified in the 30 uninspected complaints and 15 inspected complaints and to ascertain the reasons for any delays in Cal/OSHA's handling of these cases.
4 To the extent data are available, review and assess Cal/OSHA's process for reducing fine amounts and identify how often during the most recent five years employers successfully negotiated a fine amount reduced from the original amount.	• Interviewed Cal/OSHA district managers. • Reviewed state law and Cal/OSHA policies and procedures and tested 10 case files—six accidents and four complaints—to determine whether Cal/OSHA appropriately reduced fines. • Analyzed data from Cal/OSHA for fiscal years 2017–18 through 2023–24 to calculate the amount that Cal/OSHA reduced fines.
5 Review and assess whether the current fine amounts serve as an effective tool to encourage greater compliance with health and safety laws by performing the following: • Review how Cal/OSHA determines the amount of fine. • Using available data, identify the number of employers with repeat complaints and fines. • Determine whether employers with repeat complaints and fines paid the full amounts of fines.	• Reviewed state law and Cal/OSHA policies and procedures, and tested 10 case files—six accidents and four complaints—to determine whether Cal/OSHA appropriately determined initial fine amounts. • Reviewed existing research regarding fine effectiveness to determine whether fines are an effective enforcement tool. • Compared Cal/OSHA's fine amounts to various other state plans and the federal plan to determine how Cal/OSHA's fines compared. • We attempted to identify the number of employers with repeat complaints and fines by using employers' name and address data. However, Cal/OSHA does not document this information in a consistent manner, so a single employer could have multiple variations in the name and address. Nevertheless, we used these data, to the extent possible, to inform our selection of case files to test under various audit objectives and to inform our analysis of fine effectiveness.

AUDIT OBJECTIVE	METHOD
6 Review Cal/OSHA's staff vacancies to determine the following: • The number of staff positions authorized for the most recent fiscal year and the related budget. • The number of positions that are vacant and the related budget. • Whether Cal/OSHA used for other purposes the funds budgeted for vacant positions.	• Interviewed DIR human resources and fiscal services staff responsible for tracking and reporting staff salaries and wages. • Reviewed state budgets, DIR reports of authorized positions, federal funding grants, and other documents related to Cal/OSHA's staffing levels from fiscal years 2019–20 through 2023–24. • Using DIR's schedule 7A documents and similar information from the Department of Finance's website, calculated the number of Cal/OSHA staff positions authorized and vacant and the related budgets for fiscal years 2019–20 through 2023–24. We subtracted the actual amounts Cal/OSHA spent on staffing from the amounts it was authorized to spend to determine the savings associated with vacant positions. For example, in fiscal year 2023–24, we calculated almost $98 million in authorized amounts and almost $75 million in actual spending, resulting in about $23 million in savings. • Interviewed regional and district managers and DIR human resources staff to understand the context and broader impact of Cal/OSHA's staffing shortages. • Analyzed relevant statutes, state budgets, year-end reports for Cal/OSHA's key funds, and budget change proposals to determine how Cal/OSHA may have used the budgeted funds associated with its vacant positions from fiscal years 2019–20 through 2023–24.
7 Review and assess any other issues that are significant to the audit.	• Reviewed 15 accident case files—seven uninspected injuries and eight fatalities or injuries for which Cal/OSHA conducted an on-site inspection—to determine whether Cal/OSHA handled the cases in accordance with criteria in state law and its own policies and procedures. We selected these 15 cases based on the accidents' type and severity, location, citation details, fine amounts and fine reductions, and other factors. We did not design our selection to be representative of the overall population of accident inspections, but rather to position us to respond to the audit objectives and to make appropriate findings and recommendations. • Evaluated Cal/OSHA's process for conducting proactive inspections by reviewing relevant criteria in state law, strategic plans, and policies and procedures and assessing data related to the inspections Cal/OSHA conducted. Interviewed regional and district managers to obtain their perspectives about proactive inspections.

Source: Audit workpapers.

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily obligated to follow, requires us to assess the sufficiency and appropriateness of computer-processed information we use to support our findings, conclusions, or recommendations. In performing this audit, we relied on data obtained from Cal/OSHA. To assess the reliability of these data, we performed electronic testing of the data, interviewed people knowledgeable about the data, and reviewed existing information about the data. We found that DIR internal audits had previously shown completeness and data entry errors in the data. We attempted to test the accuracy of the data ourselves by tracing it to supporting documentation. Although we found some inaccuracies in the data, we were unable to complete our testing because Cal/OSHA's hard copy files did not always include the necessary information to validate the data. As a result, we found Cal/OSHA's data to be of undetermined reliability. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.

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STATE OF CALIFORNIA GAVIN NEWSOM, *Governor*

DEPARTMENT OF INDUSTRIAL RELATIONS
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June 27, 2025

Grant Parks*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Mr. Parks:

The Department of Industrial Relations (DIR) and its Division of Occupational Safety and Health, more commonly known as Cal/OSHA, appreciate the opportunity to respond to the California State Auditor's audit of, and recommendations for, Cal/OSHA (Report 2024-115). DIR is committed to continually improving its programs and ensuring the department meets its mission to protect and improve the health, safety, and economic well-being of California's nearly 20 million wage earners as well as to protect law-abiding employers from unscrupulous employers who attempt to gain a competitive advantage by failing to comply with state labor laws.

DIR acknowledges and accepts the recommendations of the audit. Prior to the audit commencing, many positive changes were in progress. The recommendations in the audit align with these ongoing efforts. Cal/OSHA will continue these efforts, addressing the various deficiencies as we work to launch a new data management system and prepare and train staff to work in a more efficient, thorough, and transparent way. We appreciate the time and effort that went into the audit and the intention behind its recommendations, which is to improve Cal/OSHA's ability to prevent workplace injuries, illnesses, and fatalities.

Staffing Level Improvement in Progress

Understaffing contributed to several of the findings identified in the audit. In recent years, DIR has been working to address structural and process issues, as well as recruitment and retention issues, that have contributed to staffing shortages at Cal/OSHA. DIR has contracted with CPS-HR to conduct workload, job analyses, and compensation studies of various classifications specific to Cal/OSHA. The information resulting from these studies will assist Cal/OSHA in determining staffing levels, minimum qualifications, and compensation levels for key classifications. DIR has already implemented many reforms to the hiring process based on this work. As a result of this and other efforts described below, Cal/OSHA is experiencing the lowest vacancy rates in several years. As of May 31, 2025, the vacancy rate for all positions across Cal/OSHA was 12%. The vacancy rate among the enforcement branch (inclusive of inspectors, district managers, and administrative support staff) was 14%. ①

The audit's staffing-related findings utilize data from fiscal years 2019-2020 through 2023-2024. (See Report Appendix B). These numbers do not reflect the current fiscal year and cover a period

* California State Auditor's comments begin on page 83.

during which DIR's hiring authority was temporarily revoked, slowing hiring and making it difficult to keep up with attrition. In 2021, following the implementation of a comprehensive corrective action plan, DIR successfully regained its hiring authority, allowing the department to resume recruitment and strengthen its workforce. As current staffing levels reflect, since 2021 DIR has made multiple systemic changes to speed up and improve hiring including: moving exams online, establishing a department-level unit dedicated to processing Cal/OSHA hiring packages, establishing a department-level recruitment and outreach unit that uses social media and attends job fairs and other events to spread the word about Cal/OSHA careers, and creating a new DIR-specific one day hiring and recruitment training for all managers and supervisors.

In 2024, Cal/OSHA established and staffed its own recruitment and retention unit within the enforcement branch to streamline the hiring process. This unit is dedicated to hiring for enforcement positions, which includes drafting interview questions and screening criteria, scheduling interviews, attending career fairs, and ensuring final hiring packages meet the requirements of the merit-based hiring process.

Recruitment for vacant industrial hygienist and associate safety engineer positions is challenging for a variety of reasons. The disparity within the division between industrial hygienists' and safety engineers' pay has resulted in new industrial hygiene graduates not considering employment opportunities with Cal/OSHA due to better paying opportunities in the private sector. It is imperative to have adequate industrial hygiene expertise on our team and DIR continues to look for solutions so that we can better address emerging, pressing health hazards like heat and wildfire smoke.

One challenge with recruiting Associate Safety Engineers is the lack of candidates with safety knowledge, skills, abilities and experience – especially in the geographic locations Cal/OSHA needs them in. To address this gap, we broadened our search to include entry-level positions, offer on-the-job training, and created partnerships with educational institutions to help develop the skills needed for the job. Additionally, we are conducting a comprehensive evaluation of our safety engineer job specifications to ensure that the required skills are necessary and appropriate for the classification.

Data Management Improvement in Progress

Many of the audit findings relate to documentation failures by the enforcement branch's field staff and the resultant inability of management to conduct quality reviews of inspections, penalty reductions, and abatement. Findings related to the enforcement branch's onsite inspections were largely based on deficiencies in case files. Cal/OSHA is working to immediately address these deficiencies through training.

Furthermore, Cal/OSHA is prioritizing the modernization and automation of its data management system, which we anticipate will reduce documentation failures and other deficiencies identified in the audit. Cal/OSHA is the largest state-run OSHA program in the country, yet the division lags behind other states in terms of technology and automation. Currently, Cal/OSHA uses the Federal Occupational Safety and Health Information System (OIS), which does not meet our state-mandated needs, and we still rely heavily on paper case files to capture many California

requirements not captured in OIS. The limitations of this system were especially felt during the pandemic when Cal/OSHA received a record number of complaints and had challenges accessing information on our enforcement activities.

After Cal/OSHA completed an operational needs assessment, it was clear that the way forward is to implement our own system that interfaces with the federal OIS. Following a lengthy requirements assessment and bidding and procurement process, Cal/OSHA selected a vendor in 2024. The multi-year project commenced and is ongoing.

The new data management system will streamline manual processes across Cal/OSHA, significantly reduce the number of new paper case files and paper forms, increase the accuracy of inspection coding, and provide public access to online services and tools, including complaint filing. This will improve efficiency, increase transparency, and enhance our performance.

To support the transition as well as the ongoing training and functioning of the new system, Cal/OSHA established a Data Interface Unit. The new unit's staff will ensure data entry is timely, accurate, and meets program requirements.

Once the system is live, which is currently targeted for early 2027, Cal/OSHA believes it will address many of the issues identified in the audit, such as reducing or eliminating paper interview notes, checklists, and abatement records that can go missing or be difficult to decipher. The new system will also strengthen the ability to audit the enforcement branch's work. As the system is finalized in the coming eighteen months and users engage with the system, there may be additional improvements made to the below described processes. Updated policies and procedures will be drafted to reflect the final system implementation. An organizational change management strategy is being developed by Cal/OSHA, in coordination with the system integrator, Accenture, to effectively train staff on the new system and revised policies and procedures.

Deciding Whether to Conduct an Inspection

Cal/OSHA takes seriously all reported accidents and complaints. Reports of imminent hazards, whether they come in anonymously or not, are to be given the same urgency and an onsite inspection should be conducted. Regional and District Managers in the enforcement branch will reiterate the importance of this prioritization and reinforce the need for accurate, legible notes detailing prioritization decisions.

In the new data management system, whenever a District Manager or Senior Industrial Hygienist (IH) decides that an onsite inspection is not warranted, they will be required to select a reason from a drop-down menu. If the District Manager or Senior IH selects "Other" as the reason, completing a comment box will be mandatory. Selecting "no inspection" for an accident that contains specific tags (e.g., heat, lead, silica, trench, etc.) will be flagged to the Regional Manager.

The system will automatically provide the District Manager, Senior IH, and Regional Manager with the employer's complete history. This will include all inspections conducted with dates and

outcomes, all letter investigations with dates and outcomes, as well as all accidents, complaints, and referrals received. Currently, managers can only see inspection history by using the publicly available Establishment Search function on the Federal OSHA website.

Letter Inspections

The new system will require that the District Manager, Senior IH, or their designee make telephone contact with the employer prior to a letter investigation. The system will log the details of these calls, including the date, time, management official spoken to, and issues discussed.

The system will track due dates and will alert management (i.e. District Manager, Senior IH, or their designee) if the employer response is overdue. The District Manager or Senior IH will be prompted to either 1) assign the complaint for onsite inspection or 2) contact the employer and offer an extension. This conversation, including date, time, management official spoken to, and items discussed, will be documented. A new due date will be entered and an extension letter will be sent out via email and/or first-class mail confirming this new date. If the employer does not respond within the extension timeframe, the complaint will be assigned for an onsite inspection.

Injury and Illness Prevention Program (IIPP)

The new system will require an inspector to complete an assessment of all eight IIPP elements during each inspection. Each element will be documented in the case file through notes and interviews with employees and management and will receive a score of 0-3. Scores of 0-1 on any element will require a citation be issued under California Code of Regulations, Title 8, Section 3203 or 1509, depending on the relevant industry and facts.

Witness Interviews

The new system will require the documentation of at least one management official interview and one employee interview before a case can be closed. A comment box, requiring an explanation, will appear if at least one management official and/or one employee interview is not logged. The case will also be flagged to a Regional Manager.

If an employee or management official declines to be interviewed, there will be an option for the inspector to log their declination, including time, date, and reason. Interview notes will be entered into the system and will be legible and accessible.

Timeliness of Closing Cases

The new system will send reminders to the inspector and District Manager and, if it is a health inspection, the Senior IH, at set intervals (60 days, 90 days, 120 days, etc.) to ensure that cases stay on track. Dates will be calculated from the earliest “last date the violation was known to exist” to ensure compliance with the statute of limitations. The District Manager and/or Senior IH will be able to check any case, at any time, to see the status of work completed, and they will have a dashboard for each inspector that shows the status of their open cases (examples: Document Request issued - pending response, Document Response under review, Notice of

Intent to Classify Citation as Serious issued - pending response, Notice of Intent to Classify Citation as Serious - response under review, Citations entered, Abatement information entered, etc.).

Evidence to Support Citations and Abatement

The new system will allow the inspector to reference photos, interviews, notes, or other documents to each violation, making it easier for District Managers to evaluate the supporting evidence for each case. The system will not allow citations to be marked as abated or corrected during an inspection without the appropriate abatement form being completed and signed by both the inspector and the District Manager or Senior IH.

Each violation will have a mandatory "abatement actions taken" field that the inspector will need to complete. Serious violations entered into the system that have not yet been abated will appear as red and will be available for review by District Manager and/or Senior IH.

Prior to the new system's rollout, enforcement branch management will reinforce the importance of legible and complete documentation of: IIPP reviews, witness interviews and interview declinations as well as abatement efforts.

Online Complaints

The new system will feature a portal that will allow, among other things, complaints to be filed online by any member of the public. All complaints, now and once the portal is live, are kept strictly confidential and complainant identity is not shared outside of Cal/OSHA. This portal will increase accuracy of complaint information and transparency. Complainants will receive messages through the portal and can view the status of their case. This feature is scheduled to go live in 2027 and is one of the audit's recommendations.

Bureau of Investigation Access to Case Information

The new system will automatically send notifications to the Bureau of Investigation to review all fatalities as well as all case files involving serious injury resulting from a serious violation.

The system will permit Bureau staff to review case files directly, eliminating the need to proactively request information from the enforcement branch.

Self-Audit Improvements

Prior to the State Audit, Cal/OSHA and DIR's internal audit team collaborated to conduct multiple audits pertaining to Cal/OSHA's enforcement activities. Cal/OSHA has also adopted one of the internal audit recommendations to redirect the Enforcement Branch self-audit to the internal audit team. Cal/OSHA will update its enforcement branch audit policy to reflect this change. Furthermore, Cal/OSHA will work with DIR's internal audit team to build the State Auditor's recommendations into future audit objectives.

Policy Improvements in Progress

As acknowledged in the audit, Cal/OSHA hired, in 2024, a policy writer to lead an update of the enforcement branch's policy and procedures manual, also referred to as the Compliance Policy and Procedure.

The manual contains approximately 170 policies, many of which include relevant forms. Most of the sections have not been updated for a decade or longer. Updates to the manual are required to be at least as effective as Federal OSHA's policies. As such, most edits and updates to this policy and procedures manual must be sent to Federal OSHA for review. The policy writer, in consultation with the enforcement branch's leadership, is reviewing and updating policies related
② to complaints, inspections, and abatement. Policies and procedures that reflect and engage the new data management system will be finalized when the data management system is operational. To revise these policies while the system is being developed and subject to change would result in efficiencies and potentially waste state resources.

We will continue implementing the audit's recommendations and will provide updates at the required intervals. Thank you for this opportunity to respond to the draft report. Should you have any questions, please contact DIR's Chief Internal Auditor, Mathew Raute, at (916) 860-2219 or Mathew.Raute@dir.ca.gov.

Sincerely,

Katrina S. Hagen
Director
Department of Industrial Relations

Cc: Stewart Knox, Secretary, Labor and Workforce Development Agency
Adam P. Romero, Chief Deputy Director, DIR
Ken Lau, Chief Counsel, DIR
Mathew Raute, Chief Internal Auditor, DIR
Debra Lee, Chief, Cal/OSHA
Danielle Lucido, Chief Counsel, Cal/OSHA
David Wesley, Deputy Chief of Enforcement, Cal/OSHA

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF INDUSTRIAL RELATIONS

To provide clarity and perspective, we are commenting on the response to our audit report from DIR. The numbers below correspond with the numbers we have placed in the margin of DIR's response.

None of the data or information we reviewed in the course of our work indicated that Cal/OSHA's vacancy rate was as low as DIR claims it now is. As we describe on page 45 and show in Figure B on page 71, Cal/OSHA's vacancy rate was 32 percent in fiscal year 2023–24 based on data from the Department of Finance's website, and the vacancy rate in Cal/OSHA's enforcement branch and several district offices was as high as 40 percent based on data DIR provided from late 2024. We explain on page 46 that DIR provided us with an internal report that showed a 21 percent vacancy rate for Cal/OSHA as of March 31, 2025, but we did not receive or audit the underlying data supporting that rate. During our audit recommendation follow-up process, we look forward to reviewing DIR's evidence of improved vacancy rates as well as documentation that it has requested the authorized positions necessary to adequately enforce workplace health and safety standards. (1)

We question DIR's implication that revising certain policies and procedures to address our recommendations before its new system is operational would necessarily be inefficient. As we discuss on page 48, many of Cal/OSHA's policies and procedures are outdated—such as one that has not been updated for 17 years—which has made it difficult for district offices to consistently comply with them. Although the new system that DIR describes could help it address many of the concerns our audit identified, revisions to Cal/OSHA's policies and procedures are still necessary to fully implement several of our recommendations. In addressing those recommendations, DIR should consider the potential costs of delaying policy and procedure updates that could improve its case handling in the months or years before its new system is operational. (2)